Repackaging ayurveda in post-colonial India: Revivalism and global commodification

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Abstract of the thesis entitled

Repackaging ayurveda in post-colonial India: Revivalism and global commodification

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This study focused on the discrepancy of ayurveda, modernity and globalization in post-colonial India. Many scholars believe that ayurveda is a part of Hinduism because of its Vedic origin and apprenticeship orientation. This study particularly argues that the practitioners and patients in modern India secularise ayurveda, with emphasising its medical importance, with ayurveda having lost its religiosity. It concludes that, although modernity failed to establish a 'religious secularism' in Indian society, it instituted a 'secular medical account', with medicine and religion remaining in tension.

Another discrepancy about ayurvedic practice in modern India is the role it has occupied in the colonial and post-colonial state. The nationalistic lobby accuses colonial

policy for the subjugation of ayurveda. By contrast, this study argues that the post-colonial revival of ayurveda and indigenization of health care reproduces colonial hegemony and inheritance.

A final ambiguity of ayurvedic medicine within modern India is related to its global commodification. Branding ayurveda as market strategy turns out to be a part of 'New Age orientalism', with ayurveda playing a part in a new consumption behaviour, which is contrary to classical practice. The rapid growth of health, beauty and sex products, and 'wellness and spa culture' for rejuvenation, are the key break here. It concludes that the entire situation has ideologically corrupted/contaminated ayurveda, and that ayurveda has lost ground as a complete way of healthy life to restore and maintain health.

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Declaration

This thesis is the result of independent investigation. Where my work is indebted to the work of others, I have made acknowledgement.

I declare that this study has not already been accepted for any other degree nor is it currently being submitted in candidature for any other degree.

Date Candidate's Signature

Preface

It was a long journey, started in October 2003, to complete this PhD project. At the very outset I acknowledge the contributions of my supervisor, Dr. K E Kuah-Pearce, of the Department of Sociology, the University of Hong Kong, for her sincere contribution and guidance in walking this elongated path. Apart from her, Department of Sociology, the University of Hong Kong provided technical and logistic supports as well as resources to complete this work. I also thank Dr. Benjamin Leung from the University of Hong Kong and Prof. William Sax from the University of Heidelberg for providing valuable suggestions about appropriate theoretical and methodological devices to create research questions and conducts ethnographic fieldwork.

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I strongly believe that this study will be a contribution for the work of students and professionals of medical anthropology, medical sociology, community health, and health social sciences.

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Abbreviations

AK: Ayurvedic Kabiraj

AP: Ayurvedic Physician

AS: Ayurvedic Student

ASF: Ayurvedic State Faculty

AYUSH: Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy

BAMS: Bachelor of Ayurvedic Medicine and Surgery

BDS: Bachelor of Dental Surgery

CCIM: Central Council of Indian Medicine

CPM: Communist Party Marxist

CRI: Central Research Institute (Ayurveda)

FP: Female Patient

FPP: Female Private Patient

IPD: In-patient Department

ISM & H: Indian Systems of Medicine and Homoeopathy

MASF: Member of Ayurvedic State Faculty

MB: Bachelor of Medicine

MBBS: Bachelor of Medicine and Bachelor of Surgery

MP: Male Patient

MPP: Male Private Patient

NMI: Native Medical Institute

OPD: Out-patient Department

PHC: Primary Health Centre

PHC: Primary Health Care

PSC: Public Service Commission

WHO: World Health Organization

Chapter One

Conceptual overview

Introduction

India, one of the world's most thickly-populated countries, has rich medical and health sciences, some of which date back to several thousand years B.C. Pluralism and co-existence of a variety of medical traditions within a selected context is a common feature in various settings of India. Some medical and health traditions existed as family or ethnic practices, others in organized institutional form. At the state level, the Indian Systems of Medicine and Homoeopathy (ISM & H), recently renamed Ayurveda; Yoga & Naturopathy; Unani; Siddha and Homoeopathy (AYUSH), which is under the Ministry of Health and Family Welfare, Government of India, recognizes the six unique and distinct systems of medicine named above. Since the 1970s the government has also given similar professional status to the practitioners of various systems. Among the above medical systems, ayurveda is the oldest, having originated and practiced in ancient India. This dissertation particularly focuses on ayurveda.

Various outsiders have invaded India throughout its history for their own political, economic and religious interests. The first invasion was that of the Aryans, followed by the Persians and the Europeans. Unlike Buddhist medicine, all the ethnic outsiders introduced their own conceptions of health, and medical traditions with a religious inspiration. For example, the Aryans introduced Vedic medicine from Sanskrit liturgical knowledge of the Veda. Vedic medicine was systemised as ayurveda and was promoted by Brahmanic religious practitioners. Arab medical

traditions, brought by invaders from Iran and Central Asia, relied on the Greek humoral concept of health. This medical tradition became popular in India as the *unani* system. Muslim rulers were particularly active in promoting this system in India. Finally, the Europeans introduced Western allopathic medicine and Christian missionaries were active in promoting this system among the Indian masses. When the British took administrative power in India, they patronised the allopathic system, and gradually allopathy became mainstream medical and health practice.

In recent Indian history, British colonial rule marked the entry of Western science and technology, which caused a decline of existing social institutions. The medical field was not excepted in these changes, and British administrative policy promoted the Western system of medicine. The broad objective of this dissertation is to re-examine some key debates about the practices of ayurveda in India. Firstly, this dissertation will explore the relationship between ayurveda and medico-religious orientation, that of Hinduism in particular. It will also explore the paradox of religiosity in ayurveda and how Indians in modern India look at the religious and secular characters of ayurveda. Secondly, this dissertation will look at the role of colonial and post-colonial states in the promotion and management of ayurvedic practices. In particular, it will explore how the colonial state intervened and subjugated ayurveda and how the post-colonial state revived ayurveda. It will further explore the discrepancy of claims during colonial subjugation and post-colonial revivalism. Finally, this dissertation will look at the global commodification of ayurveda in recent decades.

This study will particularly focus on the formal and professional sector of ayurvedic practice in the urban area. Informal sector of ayurvedic practices, especially apprenticeship education and their registration were restricted after the formation of the Central Council of Indian Medicine (CCIM) in 1970s. In modern Indian society, only the graduates from the modern ayurvedic institutions with Bachelor of Ayurvedic Medicine and Surgery (BAMS) degree are allowed to get registration under the council. However, informal ayurvedic practice still exists in the rural area, which this study ignored because of the lack of state legal framework about those practices.

The purpose of this chapter is to provide an understanding of the theoretical issues and debates and the conceptual tools used in this research. There are three major issues that we are concerned with. Firstly, there are the debates concerning the religious and/or secular nature of ayurveda. Using the cultural relativist paradigm, this chapter analyzes the relationship between medicine and religion. It also focuses on how modernity has secularised medicine and has differentiated 'medical secularism' from 'religious secularism' in India. The second issue is related to the role of politics and the state. In particular, I will analyze the connections among medicine, colonialism and nationalism in India. Finally, this chapter spells out views of the impact of globalization and global commodification of ayurveda; including the rise of consumerism, the commodification of the body, beauty and health, and the growth of 'ayurvedic wellness and spa culture'. The methodologies used in this research and the major techniques for collecting empirical and thematic data are also discussed in this chapter.

1. Religiosity in ayurvedic medicine

Medicine and religion have a common, interconnected prehistoric tradition. In the fourth century B.C., when many of the Hippocratic medical treatises were composed, around two hundred temples of Asklepios were founded in Greece (King, 1999:279). In India, many gods were featured as divine physicians in the early Vedic medical texts, including Indra, Brahma, Ashwinikumaras (*Charok, sutro sthan*[1]). It has also long been recognized that the medieval English hospital was chiefly concerned with the promotion of spiritual health (Clay, 1966; Rawcliffe, 1999: 316). Some of the religious literatures during the late medieval period in Europe contain a "rich variety of medical and surgical metaphors", which recognize a symbolic relationship between the Church and the late medieval medical profession (Rawcliffe, 1999:320).

Medicine, religion and spirituality as health concerns have been well-scrutinised and widely discussed since the classical era of anthropology. Sir Edward Burnett Tylor noted the "minimum definition of religion, the belief in spiritual beings" (Tylor, 1891:424). Tylor further noted the "doctrine of spiritual beings", here termed animism (Tylor, 1891:417). He treated animism "as belonging to natural religion" which is divided into two sections, namely "the philosophy of souls, and of other spirits" (Tylor, 1891:417). Tylor perceived the concept of the soul in primitive philosophy as related to various phenomena such as life and death or health and disease or sleep and dreams (Tylor, 1891:417). Critics fought either for or against Tylor's definition. Opponents argued that there are many people whose apparently

[1] Charok and Susrut Samhita texts are divided into various sections such as sutro sthan, uttor sthan, nidan sthan, etc.

devout religious activities involve no spiritual beings (Hendry, 1999:116). Buddhists, for example, are concerned with achieving a state "which does not require the intervention of a god or gods" (Hendry, 1999:116). Another concern of the above definition is whether religion and spirituality carry the same meaning or overlap with each other. A group of scholars view the concept of religion as a societal phenomenon, involving social institutions. However, there is an opposing view. Thoresen noted that "spirituality refers to the individual's personal experience, commonly seen as connected to some formal religion but increasingly viewed as not necessarily associated with any organized religion" (Thoresen et.al., 2001: 22). Other scholars contend that spirituality is the more inclusive term, of which religion and religiousness may or may not be a part (Thoresen et. al., 2001: 22). However, essence of Tylor's definition is the spiritual elements of religion, which constitute one of the prime foci of medical and health discussions.

As response to the evolutionary theory that dominated the Western intellectual arena in the nineteenth century, cultural relativity paradigm has been developed. Evolutionary theories generally judged non-Western cultural and social practices as irrational and superstitious idioms. Such classification caused a clear hierarchy among cultures, where Western culture stood as the top stage of evolution or civilization. Early twentieth century empiricist studies challenged such cultural hierarchy as twisted by the evolutionary perspective and introduced a new paradigm; cultural relativity, to analyse non-Western culture.

Cultural relativism is an academic discourse to overcome the ethnocentrisms of scholars. It is based on the belief that other people, or their cultures, should be

understood in terms of their own cultural logic and rational. If the scholars' goal is to truly understand non-Western, or other peoples' behaviour, they have to look for clues in their own cultures (Mc Intyre, 2006:53). Cultural relativity claims objectivity and values neutral judgement to understand other people's behaviour.

Brownislaw Malinowski related religion, magic and mythology to very specific human needs and provided a functional explanation for them. Malinowski gave especial importance to the role of myth in life and showed how deeply the myth or sacred tradition enters into the pursuits of a society and how strongly it controls the "moral and social behaviour" of the particular society (Malinowski, 1926:11). The presence of hundreds of myths, of a religious or spiritual nature, about the origin of Vedic medicine and the miraculous performance of divine physicians is key to a further understanding of the relationship between medicine and religion. Many cultural relativists have emphasised the cultural rhetoric of ayurvedic practices. They have investigated whether any connection can be established between ayurveda and Indian culture in particular. Although India experienced various outsiders' invasions and absorbed elements from different medical traditions, ayurveda not only survived but has continued to flourish up till today. An essential question raised is why ayurvedic medical practices continue to exist despite the penetration of various medical systems brought by the invaders. Clifford Geertz suggested that, "cultural systems can be best understood in terms of their capacity to express the nature of the world and to shape that world to their dimensions" (Geertz, 1973c:108). For Brown, "a medical system is an organized set of ideas referring to a particular healing tradition" and in technologically simple societies, the medical system is integrated and "often indistinguishable from the local religion"; whereas in technologically complex

societies, the primary medical system is more likely to be secular (Brown, 1998:108). The religious connotations of ayurveda especially from Geertz's perspective, has several implications. Geertz defined religion as:

> "(1) a system of symbols which act to (2) establish powerful, pervasive and long-lasting moods and motivations in men by (3) formulating conceptions of a general order of existence and (4) clothing these conceptions with such an aura of factuality that (5) the moods and motivations seem uniquely realistic" (Geertz, 1973:90)

Veer considered that "Geertz's definition hinges on a conception of religion as symbolic communication, in which a symbol is simply seen as a vehicle for its meaning" (Veer, 1998:482). There is metaphoric evidence in the practice of ayurveda that relate to Geertz's analysis. For example, the medicine described in the Charok and the Susrut Samhita texts contains a variety of animal substances, which is reflected in the practice of Hinduism (Wujastyk, 1995).

However, some critics have not supported Geertz's universalistic conception of the nature of religion. Veer argued that Geertz's definition of religion ignored the "genealogy of the modern Western understanding of religion" (Veer, 1998:482). Veer further claimed that modernity in Europe and its expansion over the world have shaped a universal concept of religion and draws a distinction between religious and secular (Veer, 1998:482-483). Geertz's understanding of religion cannot escape from the conception of religion as shaped by modernity and European colonial expansion (Veer, 1998:483). In applying Geertz's definition to the Indian context, it can be argued that Hinduism is a widely varied set of ideas and practices and that the forms of Hinduism practiced in various settings of India are different (Trawick, 1995).

Other scholars have emphasised the practical dynamics rather than the cultural logic of ayurvedic practices. According to Jeffery, allopathic medical services reached a very small section of the population, and very few practitioners trained in allopathic medicine were accessible, until the beginning of the twentieth century (Jeffery, 1988). Modern health facilities were predominantly restricted to a small sector of urban population (Jeffery, 1988). The mass of Indians, who resided in the villages, did not have access to allopathic medicine until the middle of the twentieth century.

Economic scarcity among the natives was another reason for the existence of ayurvedic healing. As Indian economy was extensively depended on agriculture and the rural peasantry led miserable lives due to natural disaster, feudal exploitation and explicit social hierarchies, they were more likely to choose the cheapest and most accessible option for healing. Ayurveda was the best choice in terms of affordability and accessibility for the rural mass. Many hereditary ayurvedic families and practitioners lived in the countryside with the rural peasantry. A majority of them came through an apprenticeship system and were knowledgeable about local herbs and plants which have ayurvedic medicinal values. Jeffery wrote about these hereditary practitioners:

> "What ever happened to the village economy, their traditional clientele would have remained, providing either the small payments by large numbers of the relatively poor, or the more substantial fees of the landed peasantry" (Jeffery, 1988:56).

Thus, instead of cultural logic or religiosity, practical need forced the mass of Indians to choose ayurveda or other forms of indigenous medical practices, especially

in rural settings. A second issue to be discussed is that of the debates that approach ayurveda and its apparent bond with religion from three angles: the presence of god and divinity; spiritual elements; and shamanistic involvement and codes of morality.

God, divinity and ayurveda

Both the *Charok* and *Susrut Samhita* texts recognize ayurveda as having a divine origin, and many godly characters have been regarded as divine physicians. Some scholars believe that all medicine is derived from God, and that medicine can not exist or be practised without the will of God. “The seeds of the art, the wonderful cures, and the powers of remedies, are in the hand of God” (Ryan[2], 1836: 3-4; cited in Mukhopadhyaya, 1922-29:5). In the ayurvedic texts, there are several gods regarded as the inventor of medicine. The origin of ayurveda mentioned at the commencement of the *Charok Samhita* text is an indication of the presence of godly characters in ayurveda. Mythologically, ayurveda originated in the heaven from Lord Brahma, a divine character who passed on this knowledge to Dakshaprajapati and then to the Ashwinikumaras (*Charok, sutro sthan*, chapter 1, paragraph 1). When diseases approached in heaven, Maharshi Bharadwai approached Indra and acquired the knowledge of ayurveda. Subsequently, Maharshi Atreya learnt ayurveda from Bharadwai and taught it to Agnivesh and other shishos (followers). Agnivesh authored the Agnivesh Tantra, or *Charok Samhita.* (*Charok, sutro sthan*, chapter 1, paragraph 1-3).

In the *Rgveda*, Lord Rudro was also addressed in connection with medical topics (Mukhopadhyaya, 1922-29:173). He is described as “the depository of all

[2] Dr. Ryan, Medical Jurisprudence, 2nd ed., 1836, pp.3-4

sciences" and "the possessor of healing medicines" (Mukhopadhyaya, 1922-29:173). Also, Lord Siva is considered to be the first proponent of the science of medicine in the *Puranas* and is quoted in many places as an authority on medical subjects (Mukhopadhyaya, 1922-29:173). All these indicate the divine origin of the Vedic medicine, or ayurveda.

Spirituality and ayurveda

The spiritual element of health has been included in the WHO holistic definition of health. Health and spirituality lie side by side, and people's illnesses are expressed by spiritual activities in many cases (Tucker, 2003:374). Spiritual elements were central in ayurveda, as the "spiritual world was offered as an explanation for positive and negative events, including those related to physical health" (Tucker, 2003:373). In ayurveda, the concept of spirituality refers to an act to connect someone with god or a supernatural being (Tucker, 2003:373). Spiritual acts include a range of religious activities such as prayer, rituals, and even faith in God (Frawley, 1997:234). There are several examples of the direct presence of spirituality in ayurvedic healing.

Firstly, the *Visa-Kanya* or the poison girls: "It was the custom in ancient India to send poison-girls as presents to rival kings, who are said to have met death by their loving caresses and embraces" (Mukhopadhyaya, 1922-29: 72). In the *Susrut Samhita* texts, royal ayurvedic *vaidyas* (ayurvedic physicians) who usually treated kings, are always cautioned about such poison girls sent by enemies to kill the king or other royalty (Mukhopadhyaya, 1922-29: 72).

Secondly, the long-lasting tradition of 'temple sleep', or residing in the temple, was another indicator of spirituality in ayurveda. In ancient times, the temples of gods offered asylum to patients suffering from disease (Mukhopadhyaya, 1922-29:75-76). In India today, similar temples continue to exist. For instances, Kalighat in Calcutta is a temple where patients suffering from various complex diseases go to get cured (Mukhopadhyaya, 1922-29: 86). Many ayurvedic *kabirajes* (title of the traditional ayurvedic practitioner) in Calcutta still hang the photo of god - especially Lord Ganesh - in their chambera and do worship in order to enhance their spirituality and efficacy in healing. The *Susrut Samhita* text recognizes the spiritual purification of young ayurvedic students before they are selected for the profession of *vaidya*.

Shamanism and moral code in ayurveda

A third aspect of ayurvedic religious flavour is linked to the nature of shamanism and to a moral code. A shaman is the mediator between the human world and the supernatural world. He/she fills many social and religious roles including those of soothsayer, therapist and interpreter of dreams (D'anglure, 1998:505). During the era of the European Enlightenment, shamanism was seen as the expression of irrationalism, the source of art, esotericism, religion, and medicine, all of which were opposed to scientific rationality (D'anglure, 1998:505). In the late twentieth century, the study of shamanism shifted and started to focus on its role in the "magico-religious use of psychotropic drugs and in shamanistic therapies", and on the "analysis of religious structures and shamanic symbols" (D'anglure, 1998:506-7). Romanucci-Ross pointed that:

> "The shaman can best be understood as a healer of the mind/body as well as the 'body politic', or community. This is achieved through his or her status as the interpreter of symbols, those

> cultural instruments for perceiving and arranging reality. They also play a role in the integration and use of symbols as generators and stylizers of patterns of systems, principally religious and medical, but also social, economic, and political" (Romanucci-Ross, 1997:215)

In shamanistic practice, usually the audience is very much involved emotionally and spiritually in the medical act and events. Although the *vaidya* does not fit the classic definition of shaman and needs to undergo professional training, it is widely believed that some of his power of healing is sanctioned by the god. The *vaidya* was given a position superior to that of a Brahmin (member of the Hindu priestly *varna*, the highest of the four categories of birth) in the *Charok Samhita* text, which considered the Brahmin to be twice born but the *vaidya* thrice born. *Vaidya* had to undergo all Brahminic processes as well as learn the *Vedas*. There is metaphoric evidence of the miraculous power of the *vaidya* in both the *Charok* and *Susrut Samhita* texts and it is widely recognized that not everybody can pursue the career of successful *vaidya*. For instance, the *Charok* text noted that:

> "A skilful *vaidya* would save the life of a king from premature death while a professional priest having knowledge of a spell would save the king from unknown poisoning. It was explained in the Astanga Veda by the god Brahma. A steady *vaidya* should discuss with the priest before performing his act to treat the king". (*Susrut*, *Sutra stahn*, chapter 14, paragraph 6-7).

The above paragraph explains the relationship between the *vaidya* and the priest. A priest is supposed to be a mediator between the superhuman world and the human world. Morality or ethics, which is called *Dharma,* is another important aspect of ayurveda. Dharma has been regarded in both the *Charok* and *Susrut Samhita* as one of the four major goals for all humans in the universe. The *Susrut* notes the moral

code of an ideal physician and warns him not to take any unwanted advantage of a patient during treatment. The text states that:

> "The vaidya should avoid cohabiting, having sex, accompanying or even making fun with another's wife. He should not accept any other goods or services except food and beverage from other's wife" (*Susrut*, *sutro sthan*, chapter 10, paragraph 8).

Similarly, the *Charok Samhita* text includes several paragraphs about the quality of an ideal *vaidya*, such as:

> "There are three categories of vaidya in this universe; Saddochor (disguised), Siddoshadhito (parasite), and Vaidyagunzukto (knowledgeable). Saddochor vaidyas are ignorant persons who use the instruments, medicine, books, personality, and dress code of a vaidya and claim themselves as vaidya although they are not knowledgeable at all on treatment. Some vaidyas who use the fame of other famous vaidyas although they are not knowledgeable but function as parasites are called Siddoshadhito vaidyas. Those vaidyas who are skilful to implement medicine, knowledgable about Vedic text, provide cure and save people's life are the vaidyagunzukto vaidya or true physicians" (Charok, sutro sthan, chapter eleven, paragraph 5).

Medicine, modernity and secularism

The above section has examined how medicine, ayurveda in particular, is connected with religion. However, there is a strong trend among scholars who perceive medicine to belong to the secular domain, especially in the case of allopathic medicine. Many practitioners and researchers claim its scientific rationality and evidence-based charisma, instead of any spirituality or religious flavour. They stigmatise religious connections of medicine as non-scientific/superstitious. It is

necessary here to explain how modernity and European ‘enlightenment’, under the colonial rule, constructed a secular outlook in the medical arena of India.

What is modernity?

For Jonathan Spencer, “the word modern has its roots in European intellectual life in the second half of the nineteenth century” and it is a “broader intellectual and cultural movement” (Spencer, 1998:376-377). Although the intellectual foundation of modernity was grounded in literature and fine arts, it gradually penetrated into the capitalist societies with growing rationalization. Thus, modernity serves the purpose of Western capitalism or industrialization, which marks the distinction between the West and non-Western traditional societies (Spencer, 1998: 378). Modernity thus serves as an intellectual discourse which is based on pairs of subjective binary oppositions: modernity/traditionalism, scientific/superstitious, etc.

Allopathic medicine is a relatively new phenomenon as compared to other systems of medicines such as the ayurveda and *unani* systems. Allopathic medicine achieved its dominant position with the hand of industrial capitalism, firstly in the West and gradually all over the world, and served the interest of capitalist class (Baer, et al., 1997:12). Allopathic medicine was brought in India by the European expansion and later imposed under the shadow of colonial administration. The London Missionary Society in southern India started medical relief during 1830s with a belief that “It could open a wide and effectual door into the hearts and minds of the natives, if only because medical aid was one of the very few forms of help which the Hindu is at liberty to receive” (Arnold, 1993:244). By contrast, most of the ayurvedic and *unani* medicine and health care services during pre-colonial and early colonial India

were provided by a group of professional medical practitioners not associated with the Hindu temple or Muslim mosque. The irony here is that, although allopathic medicine could ensure its secular nature and was provided and supplied by the Christian missionaries, ayurveda and *unani* medicine remained associated with superstitious beliefs despite the fact that they were not provided by the Hindu priests or Muslim imams. For Veer, “It was not universal secularism, but Christianity, which spread along with European expansion” and the “religious regime was intimately tied up with the expansion of colonial states” (Veer, 1998:483). The missionarization of Indian peoples was an important feature of European expansion. Before the colonial invasion, ayurveda was in the mainstream. However, the colonial outlook stigmatised ayurveda as ‘traditional’ and opposed to ‘scientific allopathy’.

2. Ayurveda, colonialism and nationalism

While some scholars viewed modernization and the secularization of medicine in India as heavily influenced by British colonialism, the development of allopathic medical dominance was also influenced by capitalist development. According to Marxist and neo-Marxist perspectives, many political economy authors “comment on the cultural crisis of allopathic medicine, in which health care under capitalism is perceived as largely ineffective, overly expensive, under-regulated and vastly inequitable” (Lupton, 2003:8). Marxist scholars focus on the class relations and the role of the state concerning the health system, the commodification and commercialization of health care, and the “ideological nature of medical knowledge” (Morsy, 1990:33). As influenced by Marxism and neo-Marxism, critical medical anthropology recognises various patterns of medical pluralism that existed in complex societies although the dominant status of allopathic medicine is “legitimized by the

modern state and laws" that give allopathic medicine more protection (Baer, et al., 1997:29). This branch of medical anthropology differentiates between 'Western' and 'non-Western' medical systems, or Western medicine and indigenous medicine, respectively, as a dialectical relationship (Morsy, 1990:34). David Arnold mentions the introduction of allopathic medicine in India as a colonizing process which became an important topic for some anti-colonial and nationalistic scholars and a "key factor motivating the revival and professionalization of traditional Indian medicine" (Arnold, 1993; Hollen, 2005:91).

From a neo-Marxist perspective, Antonio Gramsci's idea of ideological hegemony is of relevance here. Gramsci posited that political leadership could be based upon consent rather than coercion and that such consent might be secured through the diffusion of the worldview of the ruling class (Gramsci, 1978). This Gramscian thought corresponds to the nature of modern ayurvedic education. The pattern and structure of today's ayurvedic undergraduate and postgraduate education follow a Western framework, which was put in place in India by the British colonial administration. Traditionally, ayurvedic practitioners learned ayurveda through an apprenticeship system. However, the British colonial rule brought ayurvedic education under a Western institutional framework. The ayurvedic medical system consisted of an integrated curriculum and incorporated a significant number of courses from the allopathic medical systems. Gramscian analysis of hegemony is particularly relevant here, as he noted that any dominant social group or core social group imposes its dominance for the purpose of taking over power and holding it (Gramsci, 1978). A continuous struggle before and after the revolution is a pre-requisite to prolong the dominance (Gramsci, 1978). In other words, a core social

group has to establish an ideology, values, and a way of thinking in all spheres of civil society in order to stabilize its power (Gramsci, 1978).

Gramsci used the idea of hegemony in order to explain the predominance of a ruling class, which could be achieved by either coercion or consent. It is a relational idea, with various interpretations in social sciences. In its conventional sense, hegemony refers to a social, political, economic or cultural condition rooted in the equation of subordination and dominance. In the colonial context, “hegemony refers to the conventional modes of arranging compliance to constituted authority, and this authority’s search for a langue which makes such compliances assured and habitual” (Kaviraj, 1994:26). Hegemony functions as a tool for creating legitimacy for the colonial apparatus of control to integrate a colonized society with colonial arrangement. From this perspective, hegemony basically suggests “the ways in which colonial ideology served by the ruling class by helping to make their rule appear natural and legitimate” (Engels and Dagmar, 1994:3). However, hegemony faces enormous resistance from the subordinate or oppressed, and fell under diversities of interests in many European colonial regimes.

Gramsci highlighted two major super structural ‘levels’: ‘civil society’ and ‘political society’ or ‘the state’ (Gramsci, 1978:12). “These two levels correspond on the one hand to the function of ‘hegemony’ which the dominant group exercises throughout society and on the other hand to that of ‘direct domination’ or command exercised through the state and ‘juridical’ government” (Gramsci, 1978:12). In this rather simplified sense, the emergence of Western allopathic medicine in India implies both the hegemonic and coercive means. The medical class trained in

allopathic medicine was formed among native Indians by the end of the nineteenth century, and allopathic medicine was privileged by colonial administration through administrative regulations. Under the colonial eye, indigenous medicines were stigmatised as social and religious practice which was medically inefficacious (Bala, 1991:17). Many commentators agreed that the dominance of allopathic medicine in prestigious and well-paid areas was due to state patronage, while indigenous medical systems such as ayurveda or *unani* declined because of administrative reluctance and negligence (Bala, 1991: 17-18). The hegemonic power of allopathic medicine reflected in post-colonial India and the growth rate of allopathic colleges were much greater than that of ayurveda even after Indian independence.

Jean and John Comaroff argued that colonial expansion during the nineteenth century and Western medical intervention did not simply determine the rise of allopathic medicine or an ideology of imperial control. Rather, they showed how each "played off the other within the unfolding of a particular historical process" (Comaroff and Comaroff, 1992:216). Nineteenth century Western medical intervention and the colonizing project were inseparable in many senses, and the interrelation between them was dialectical. Although the imperial establishment and biomedical interventions did not engage in the same reciprocal relationship in some parts of the European colonial regime, there is clear "elective affinity" (Comaroff and Comaroff, 1992:232).

Camoroff and Comaroff concluded that colonialism was not a one-way project in which colonizers imposed their mission upon colonized, nor was it a two-sided affair in which the colonized had some influences on the way the colonizers acted

(Comaroff and Comaroff, 1992:232). Rather it was a "complex business", given the fact that "British imperialists were actively engaged in transforming their own society" in the colonial setting (Comaroff and Comaroff, 1992:232). The colonizing mission underwent a continuous reconstructing process, which Comaroff and Comaroff called "the colonization of consciousness and the consciousness of colonization" (Comaroff and Comaroff, 1992:236-293).

In India, the colonial state had followed two mutually exclusive strategies to create colonial legitimacy in different periods of history. Firstly, at the beginning of East India Company rule, officials of the Company accepted traditional pre-British or Mughal social and cultural idioms and tried to translate European political existence into native Indian cultural and symbolic order (Kaviraj, 1994:37). However, this strategy did not last long because of its contradiction with the colonial principle. While British colonialism was justified by its rationalist argument based on the discourse of the European Enlightenment, the acceptance of traditional institutions and cultural idioms abandoned the further advancement of European rationalist rights and the restructuring of native Indian social, political, cultural and economic institutions (Kabiraj, 1994:37-38).

Colonial administration did not continue such a strategy long time and as soon as the political control of India was secured it went for a second strategy to create legitimacy (Kabiraj, 1994:38). Western education was introduced to produce a new middle class social group which ensured Western ideological hegemony, and gradually Western education created the condition for a shift from pre-colonial imperial state to colonial rationalist state (Kabiraj, 1994:38).

Apart from the above debate about colonial hegemony in the Indian health sector it is important to see how the nationalist lobby pursued the religiosity in Indian medicine. Mondol states that "Secularization encompassed two key transformations: the first was the rise of the absolutist state which wrested the basis of political legitimacy from the metaphysical realm underwritten by religion to a physical realm underwritten by a centralized state" (Mondol, 2003:23). The second major transformation Mondol noted was the "establishment of a separate and entirely secular judicial system rather than from the more general and Universalistic cultural codes that had preceded it" (Mondol, 2003:23). Throughout the British colonial period in India it is evident that allopathic medicine was introduced in order to fulfil the needs of the colonial judiciary system. This was especially so in the criminal offence and post-mortem cases, where the native Indian physicians from non-allopathic background did not have the knowledge to handle the situation. Under the colonial legal system, allopathic physicians trained in forensic medicine were essential to maintain this judiciary system.

What does nationalism mean for India?

In colonial societies, such as India, "one of the strongest foci for resistance to imperial control has been the idea of nation" (Ashcroft, et al., 1995:151). Benedict Anderson stressed that "nationalism has enabled post-colonial societies to invent a self image through which they could act to liberate themselves from imperialist oppression" (Anderson, 1983:15). For Jonathan Spencer, "nationalism is the political doctrine" that claims "the idea of a group of people with a shared culture, often a shared language, sometimes a shared religion, and usually but not always a shared

history”; which give them the right of political legitimacy to rule themselves (Spencer, 1998:391). In the above quotations there is a common feature that the principle of nationalism involves ‘a sense of belongings’ or feelings of consciousness that people use to develop their own group identity.

In an attempt to clarify the formation of nation-states after the dismantaling of colonial rule, Chatterjee noted three distinct types or ‘models’ of nationalism that emerged in world history. Firstly, ‘Creole nationalism’ of the Americas was “built upon the ambitions of classes whose economic interests were ranged against the metropolis” and it also “drew upon liberal and enlightened ideas from Europe” (Chatterjee, 1995:164). Secondly, the linguistic nationalism of Europe became “a model of the independent national state which henceforth became ‘available for pirating”. Third was the official nationalism: “typically, Russia which involved the imposition of cultural homogeneity from the top, through state action” (Chatterjee, 1995:164). For a third world nation state like India which had undergone British colonization for about two hundred years, nationalism was born as an anti-colonial resistance. India is culturally and linguistically a diversified country where people from different states speak different languages in their everyday lives. The Indian central government recognizes several languages as official languages, although English and Hindi have been widely used in recent official documents. European linguistic nationalism did not develop in India as it did in Europe although the central Indian government is trying to promote Hindi all over the country. Since independence, Indian nationalism has been dominated by political interests, and religion had been used as a key trope to mobilise people under nationalistic

inspiration by some political parties, who have tried to promote Hindu nationalism, although other parties have been prone to keep a secular Indian national identity.

Chandra brought an economic perspective to analyse Indian nationalism. In his view, the nineteenth century marked the entry of the Indian economy into world capitalism under the process of modernization and gradually transformed India into a "classic colony" (Chandra, 1979:4). As a result, "colonialism in India was as modern a historical phenomenon as industrial capitalism in Britain" (Chandra, 1979:4). However, colonial modernization and capitalist intervention influenced not only the Indian economy but also other social arenas such as politics, culture, administration etc., which Chandra called a "colonial cultural revolution" (Chandra, 1979:7). The feelings of exploitation by the colonizers gradually developed into a sense of resistance in both political and economic arenas by native Indians, and this was called nationalism.

One of the pre-eminent features of Indian nationalism is its elitist character, as it was imposed from the top of the society. While India was a stratified society in terms of caste, class, religion, locality and ethnicity, not all the segments of the society participated or had similar access to participation in the nationalist project. The lack of an all-Indian political consciousness among people from different locals and provinces who hardly knew each other, spoke different languages and lead different lifestyles in terms of dietary practices, rituals, etc., was the key weakness under the common nationalistic framework (Seal, 1973). The situation did not change even after independence and the nationalist movement since India's inception to 1947 has been a bourgeois democratic movement (Chandra, 1979:135). A potential danger

of this bourgeois nationalism in India is that the political or social elites use nationalism to maintain their own power. Ashcroft stated that “while nationalism operated as a general force of resistance in earlier times in post-colonial societies, a perception of its hegemonic and ‘monologic’ status is growing” (Ashcroft, et al., 1995:151). Nationalism appeared in post-colonial India as similar to colonialism because of its elitist character.

In a post-colonial Indian society, it is expected that a citizen must participate in a modern lifestyle, work in industries or modern institutions, and engage in contemporary politics, but also hold the identity of his/her own nation; as Mondol puts it, “one should be modernized but never westernized” (Mondol, 2003:48). The medical field in India, especially the practice of indigenous medicines, encountered a similar paradox from the very beginning of its connection with the nationalist movement. It was not until World War 1 that colonial policies expressed concern for the Indian masses, as a result of the enormous pressures for change from the nationalist leaders who blamed colonial rule for the decline of native Indian tradition, culture, religion, science, etc. (Bala, 1991:16). While indigenous medical knowledge was linked with the cultural glory of the Indian past, the move to revive indigenous medical systems, ayurveda and *unani* in particular, can be seen as a part of the rising national consciousness (Brass, 1972; Bala, 1991:17).

3. Globalization and global commodification of ayurveda

A third issue of this research is the process of globalization and commodification of ayurvedic practices and products as global commodities. The trans-national and global character of medicine is one of the pre-eminent features

developed over the last few decades. Indigenous medicine, which is usually claimed to be part of a cultural system within a particular geographical and political tradition, is a good example. Many scholars believe that the trans-national era of medicine has been created or caused by the dissatisfaction or paradoxical claims of nationalism. Alter perceives "trans-nationalism as a cultural process linked to globalization" although various Asian medical systems practiced across the region are usually focused on the "bounded regional form of practice within the framework of contemporary nation-states" (Alter, 2005:3). Alter raised a few interesting questions regarding the state, which are concerned with the modernization of indigenous medicine in Asia and the role of trans-national hegemony to limit the nationalist articulation of indigenous medicine (Alter, 2005:6)

There are several problems of the nationalistic claims about indigenous medicine. Firstly, different nation states claim the origin of the same medicine as their own. An example is Chinese acupuncture, which has been extensively practiced in Chinese communities for several thousand years (Needham et al. 2000; Alter, 2005:26). However, Dr. Ashima Chatterjee, a former MP in the Rajyasabha of the Government of India, proclaimed in a speech on July 2, 1982, that "acupuncture was not invented in China but was, rather, an Indian innovation" (Alter, 2005:26). During another government-sponsored conference held on August 10, 1984, the president of the Indian Acupuncture Association, Dr. P. K. Singh, provided data and analysis showing that acupuncture had originated in India (Alter, 2005:26).

A second problem related to nationhood is the emergence of different nations in the same region during the post-colonial era. British India is a good example, as

several nationalisms materialized after the colonial regime such as India and Pakistan. It is thus possible to argue that the development of ayurveda took place across all these countries. Thus each of these nations can claim ayurveda as their own. Final discrepancy of nationalistic claim is related to the overlapping ideas and concepts among different medical systems. According to Alter, "the idea and knowledge of ayurveda" was "transported through an exchange of ideas that is probably more extensive than the borders of any one of the South Asian states or all of them put together" (Alter, 2005:2). In addition, there is conceptual overlap between key concepts in the various medical systems of Asia, such as *yin/yang* in Chinese and *prakrti/purusa* in ayurveda (Alter, 2005:2). Alter concluded that medical theory is derived from the politics of 'trans-national nationalism' (Alter, 2005: 22).

Global commodification

The term 'commodification' has been used in a variety of different ways in the social sciences. Nichter and Nichter (1996:269) define health commodification as "the tendency to treat health as a state which one can obtain through the consumption of commodities, namely, medicine". Bode explored how indigenous medicines have been transformed into modern health products for middle class Indians over the last few decades and how trans-national reworking of traditional Indian medicine in the West has transformed the practices of Indian medicine within and outside of India under the banner of globalization (Bode, 2002; Hollen, 2005:91).

Giddens categorized the views about globalization under two broader headings - namely, 'sceptics' and 'radicals'. The sceptics tend to be on the political left,

especially the old left (Giddens, 1999: BBC Reith lecture 1). I quoted two paragraphs from Gidden's writing about the differences between the two sides:

> "According to the sceptics, the global economy isn't especially different from that which existed at previous periods. The world carries on much the same as it has done for many years. Most countries, the sceptics argue, only gain a small amount of their income from external trade. Moreover, a good deal of economic exchange is between regions, rather than being truly world-wide" (Giddens, 1999: BBC Reith lecture 1).

By contrast,

> "The radicals argue that not only is that globalization very real, but that its consequences can be felt everywhere. The global marketplace, they say, is much more developed than even two or three decades ago, and is indifferent to national borders. Nations have lost most of the sovereignty they once had, and politicians have lost most of their capability to influence events. The era of the nation state is over" (Giddens, 1999: BBC Reith lecture 1).

For Giddens, neither the sceptics nor the radicals have properly understood either what globalization is or its implications for us and both groups see the phenomena almost solely in economic terms (Giddens, 1999: BBC Reith lecture 1). By contrast Giddens marks globalization as a political, technological and cultural, as well as economic process (Giddens, 1999: BBC Reith lecture 1).

Walters perceives very similar views as those of Giddens, delineating globalisation as a social process and stressing three arenas of social life inherent to globalisation - namely, economy, polity and culture (Walter, 1998). For Walter, the economic aspect of globalization refers to social arrangements for the production,

exchange, distribution and consumption of goods and tangible services (Walter, 1998). Subsequently, the political arena of globalization involves the concentration and application of power; and the cultural arena has to do with various symbols, beliefs, tastes and values (Walters, 1998).

Allan Cochrane and Kathy Pain (2004) also made a similar type of categorization, with different terms for the origin and nature of the globalization debate. They called the positions globalist, inter-nationalist and transformationalist. According to Cochrane and Pain:

> "The globalists see globalization as an inevitable development which cannot be resisted or significantly influenced by human intervention, particularly through traditional political institutions, such as nation-states. The inter-nationalists argue that the significance of globalization as a new phase has been exaggerated. They believe that most economic and social activity is regional, rather than global, and still see a significant role for nation-state. However, the transformationalists believe that globalization represents a significant shift, but question the inevitability of its impacts. They argue that there is still significant scope for national, local and other agencies" (Cochrane and Pain, 2004:22-23)

Many scholars believe that if globalisation is an ever-stronger process with deep historical roots, ayurvedic globalisation would have started when the Indus valley region was conquered first by the Aryans and then by the forces of Alexander the Great. The *Aryan* people invaded India and authored the ancient Indian *Vedas* texts, and this event is considered the foundation of ayurveda. The Muslim occupiers brought the second phase of ayurvedic globalisation since they introduced a new medical system, *unani*. The British invasion contributed another stage of ayurvedic globalisation with the prologue of the introduction of allopathic medicine. If

globalisation is co-temporal with the Western style of modernisation and the development of capitalism, ayurveda will embrace certain aspects of capitalism. Ayurveda will tend to develop from its simple origins and become more capitalist in character through absorbing features of the capitalist market, e.g. new consumption patterns, commoditisation, specific patterns of manufacturing, fashion and taste, the rise of new products, intellectual trends, technological innovations, etc.

Over the last few decades many trans-national and national drug manufactures have started to invest in the indigenous medical field and have promoted aggressive marketing campaigns for their health products, with middle class consumers as their target. Many drug manufacturers have promoted indigenous medicine as a healthy alternative to Western drugs by emphasising the herbal contents. Aggressive marketing for 'beauty and health' products and 'wellness and spa culture' under the banner of indigenous medicine are indicators of 'new age desire'[3] about ayurveda. Since middle class consumers are the prime target of the health products and spa culture, it is important to provide an operational definition of middle class in India.

Middle Class in India

Class differentiation in India, especially its internal structure and determinants, has changed over time. Caste hierarchy was crucial to determine class status in the pre-colonial setting, but other social capitals such as modern education or technical skill became important during the colonial era. The rise of an ideologically and socially dominant middle class in India was rooted in the history of its colonial past.

[3]The term was used by Selby in her works entitled "Sanskrit gynaecologies in postmodernity: The commoditization of Indian medicine in alternative medical and new-age discourses on women's health".

In particular, the creation of the today's Indian middle class was historically associated with the development of colonial education policy (Fernandes, 2006:2). The colonial administrative system and institutional restructuring created a new social class in order to fulfil its own need. One of the pioneer British colonial administrators, Thomas Macauley, said in a speech that: "We must at present do our best to form a class who may be interpreters between us and the millions we govern; a class of persons, Indian in blood and colour, but English in tastes, in opinions, in morals and intellect" (Varma, 1998:2).

English language skill became one of the pioneer tools to determine Indian middle class during the colonial regime. Indian national movement and a large number of nationalist leaders were educated under colonial education system and fluent in English. Thus, nationalist movement in India became a middle class elite movement. Unlike French or Dutch, British colonial power allowed English educated native Indians to enter colonial administrative services and English language skill was used as a passport to enter the legal profession and colonial judiciary system (Varma, 1998:4). Most of the first generation Indian legal professionals came from urban middle class elite or rural feudal lords' family. English language skill further made a clear division between illiterate mass Indians and 'baboos', a term used to address an English educated native Indian who can write English (Varma, 1998:4).

Apart from colonial education, literacy and institutional arrangement, there are other indicators that symbolize the middle class status in modern Indian society such as perception of modern contraceptive use and fertility control, creation of new public spheres, civic association, etc. Indian growing population and demographic realities

during late nineteenth century was considered as one of the major barriers for the overall progress and development of the country. Middle class with Western values accepted the idea quickly and promoted a fresh perception that it is necessary to control the high fertility among subaltern mass for the progress of the nation. Such fertility control intervention naturalized the power of middle class male elite over subaltern strata (Ahluwalia, 2004:183). Borrowing Western enlightenment ideas and using such new apparatus of public spheres and interest constituted the emerging middle class in colonial India (Joshi, 2001:24)

Also, the structural characteristics of the political economy of colonialism such as full-fledged industrialization shaped the rise of the middle class because of the necessity of industrial managerial and supervisory staff (Fernandes, 2006:4). There are several distinctive characteristics with regard to the rise of the middle class in colonial India. First are, specific kinds of socioeconomic resources, such as access to English education and other modern forms of professional employment; Second, an emerging set of political claims of public representativeness, or democratisation in civic life (Fernandes, 2006:2). However, the boundaries of the emerging group are fluid because of the fact that individuals from varying social segments can acquire certain social capital such as education, credentials, skills, and cultural resources and get access to membership in this newly created middle class (Fernandes, 2006:xix).

The characteristics of the Indian middle class had taken on a new shape in recent decades because of the neoliberal economic policy and the political dynamics of the globalization. Post-1990s economic liberalization generated a shift in the role of the middle class, such as in their attitudes, lifestyle, consumption practices, etc.

(Fernandes, 2006:xv). Fernandes identified four popular capitals characterising the Indian middle class status today: 1) that of the media and public sphere; 2) participation in the labour market; 3) residence in urban neighbourhoods; and 4) participation in democratic politics (Fernandes, 2006:xxx). Apart from this, various consumer items such as cell phones, cars, washing machines, and colour televisions have also produced an image of recent middle class identification (Fernandes, 2006:xv). Today's Indian middle class have access to new jobs in the labour market, especially in various service sectors, IT sectors and consumer products sector, at attractive wage levels. This is qualitatively different than in the past, but not structurally so. The state control economy and socialist ideology during the initial phase of the Indian independence has revered with the rise of a new consumption culture during the era of globalization. Urban middle class consumers today are portrayed as the representative citizens of liberalizing India (Fernandes, 2006:xv).

Although there is qualitative difference between the middle class during colonial regime and neo-liberal era, Indian middle class structurally remain the same in large scale. Colonial education policy remains unchanged even after decolonization and English language still dominant in administrative and academic arena. One major reason for the dominance of English as official language is that India is vastly diversified in terms of language and culture. Most of the state has its own dialect and it is hard to communicate with peoples from other states without a common language. In the post-colonial India, English took that advantages and became popular modes of communication for the emerging middle class elites. It also has a foreign and International flavor which native Indian languages don't have.

However, class formation and structure in colonial and postcolonial Indian society is not rigid phenomena. An upward mobility is one of the central characteristics of Indian social hierarchy. Majumdar had showed how cricket during the early years of twentieth century symbolized a ladder of upward social mobility among the relatively deprived segment of Indian society (Majumdar, 2007:160). A group of native Indian cricketers in the national team came from the lower caste or class and draw benefit from the ruling elite because of their sports skill. Gradually, they upgraded their status through becoming popular national hero and acquired elite middle class character. Cricket in modern India had emerged as an attractive choice for lower middle-class to upgrade their socio-economic status (Majumdar, 2007:159-160).

'Consumerism' and 'new age desire'

Consumerism is one of the key features of modern capitalist society, in which various social services have been transformed into commodities. Massive industrialization and urbanization have created a new consumer class in urban space in the modern era with the rise of the economic affordability of new consumer products. One of the pioneer tools to reach the consumer in modern society is advertising, and various electronic and print media have been used to propagate the advertisement of consumer products. Such advertising imagery also reflects society's current values, and at the same time their frequent repetition ensures the leading role of advertisers in the development of consumers' preferences (Laws, 1996:202). Although traditionally health is considered social service in many welfare and socialist states, consumer culture has reversed the 'service content' of health to the

extent that it has become a commodity; thus, health is viewed as a commodity, and people became the consumers of health care.

In the globalization of ayurveda, the media play an important role. In general the "images used in marketing frequently emphasise the beauty of female and male human bodies, portraying them as vehicles of pleasure and self-expression in leisure settings associated with hedonism and display" (Law, 1996:202). Apart from health products, there is also the promotion of an ayurvedic lifestyle. Associated with the promotion of ayurveda as a global commodity, the promotion of the body is another significant trend. In anthropological literature there are several classifications of way to perceive the body, such as: the medicalized body; the sexual body; the disciplined body, etc. (Lupton, 1994). The medicalized body is most directly related to the medical management of disease (Lupton, 1994). The sexual body got attention in early ethnographic study of primitive cultures, especially to determine gender relations. However, recent anthropological study of the sexual body has put more emphasis on power relations. The sexual body is particularly significant for the promotion of health products as a means to sexual power, and sexualizing images are used to represent the practice of indigenous medicine in modern society. Contemporary ayurveda caters to the needs of the sexual and medicalized body through a large array of health and enhancement products ranging from those with medicinal properties to purely cosmetic products.

Women, body and beauty: A theoretical overview

Decorating the human body in order to materialise beauty is a prehistoric phenomena found among various ancient civilizations, in myths and archaeological

monuments. It is not uncommon that many ancient buildings, monuments, tombs, forts and other gigantic architectural structures retain images of the human body, with impressive dress and colourful body arts. Indigenous people of various aboriginal groups draw different types of art on their bodies to decorate them and make them more attractive. The Chinese, in historical time, developed the concept of the foot binding of women, in order to alter the human body from its natural state and maximise its beauty. Many European women in the sixteenth century bound themselves into corsets of whalebone and hardened canvas (Saltzberg and Chrisler, 2006:164).

However, human bodily beauty practices were opposed by feminist critics during the late twentieth century. Concerned groups started to argue that beauty ideals and practices on women's bodies symbolise their oppression. Feminist arguments concerned specific case examples, such as foot binding in olden China, that "clearly illustrates the objectification of parts of the female body" - that such social norms gradually forced women to conform to the existing beauty ideals (Saltzberg and Chrisler, 2006:163). Feminist schools further argued that the idea of beauty, or the beautiful body, always refers to the female body, whereas attractive male bodies are described as handsome bodies. The word 'handsome' derives from hand, and refers to action (Freedman, 1986; Saltzberg and Chrisler, 2006:163). The ideals and values associated with the idea of 'handsome' are rarely employed in the description of beautiful. 'Handsome' is achievement and strength quality, while 'beauty' is a decorative quality, given the fact that "men are instrumental; women are ornamental" (Saltzberg and Chrisler, 2006:163).

Groups raised concerns that give good support for the idea of the objectification of women according to beauty ideals and practices. Firstly, throughout history it is found that the necessity of beauty practices for women was not determined by women themselves; neither were such practices an individual woman's choice. The existing pressure of male dominance forced them to choose various beauty practices such as dieting, depilation, makeup, etc. Women's femininity for male attraction and related beauty practices are not natural but represent 'ritualized subordination', and such femininity is influential in the construction of harmful beauty practices (Jeffreys, 2005:1-3).

Secondly, beauty has become an exclusive commodity, particularly for elite women, who spend a large amount of their incomes for body-beauty care. Although the perception of beauty varies greatly across cultures and changes over time, there is an increasing trend to quantify women's beauty, portrayed through various agencies such as the media. Within this effort, beauty falls under subjective measurement, and in case the images of beauty change, women's bodies are also expected to change (Saltzberg and Chrisler, 2006:163). Trends have caused changes in the ideal standards for the female body many times, even within the short period of the twentieth century. The ideal female body during the 1920s was characterised by slender legs and hips, small breasts, and bobbed hair and physical and social activity, while the ideal shifted during the 1960s to youthful, thin, lean bodies and long, straight hair. In the 1970s, a thin, tan, sensuous look was popular; during the 1980s a slim, muscular, toned and physically fit female body became the ideal (Saltzberg and Chrisler, 2006:164-165). All these changes of the body ideal have led to various interventions in the female body to ensure beauty as a capitalist commodity.

Thirdly, achieving an ideal body and beauty means a woman may need to pay high physical, economic and psychological costs, such as disastrous side-effects on health, social insecurity and vulnerability, etc. However, despite these enormous side-effects and physical consequences, women take the risk of various interventions on their bodies, such as breast enlargement because of media norms of the beautiful breast, which shape the perceptions and desires of potential lovers, spouses, male counterparts and employers. Women are "neither dupes nor critics of sexist culture; rather, their overriding concern is their right to be desired, loved, and successful on its terms" (Bordo, 1993:20). Recent fashion trends and women's increasing fascination towards them cause vulnerability in a variety of ways, such as that of long hair and dangling earrings, which have gotten caught in machinery and entangled in clothing and led to injury; and high heels and tight skirts, which prevent women from running from danger (Saltzberg and Chrisler, 2006:165). All these impacts lead women into socially insecure positions.

Also, attaining various beauty ideals require money and forces women into economically vulnerable positions (Saltzberg and Chrisler, 2006:166). For instance, there is a growing trend of using natural/herbal cosmetics in order to maximise natural beauty and minimise side-effects (as portrayed in the media) which are expensive but most popular and are thought to be most effective.

In addition, psychological costs of ensuring beauty ideal include those arising from the social pressure for skinny bodies, which can be directly linked to the

increasing incidence of anorexia nervosa and bulimia, unhappiness, misery etc. (Saltzberg and Chrisler, 2006:167).

Finally, since the body is most important for women under the idealization of beauty, women are trapped by men's sexual desire, violence or aggression and failure of will. "Even when women are silent, their bodies are seen as speaking a language or provocation", appealing to males and expressing femaleness (Bordo, 1993:5-6). For instance, the meanings of fat and skinny bodies and the moral significances attached to them cause tremendous division among women as biological and social identity and "revealing the slender, fit body as a symbol of virile mastery over bodily desires that are continually experienced as threatening to overtake the self" (Bordo, 1993:15).

However, fundamental disagreement emerged in the 1990s among various feminist schools as to whether beauty practices represent women's subordinate status or whether they could be seen as the "expression of women's choice or agency". The idea of 'women's subordination' to beauty/ fashion practice was challenged by a new breed of liberal feminists. They argued that women have been empowered over time by various feminist movements to choose beauty practices, and so they can no longer be seen as oppressive (Jeffreys, 2005:5). Meanwhile, other feminist schools continued to argue that women's' individual choice or agency concerning beauty/fashion practices were severely constrained and that such choice is made "within a context of women's relative powerlessness and male dominance" (Jeffreys, 2005:6). They further noted that "the imagination of the female body was of a socially shaped and historically colonized territory, not a site of individual self-determination" (Bordo, 1993:21).

Another issue that concerns the global commodification of ayurveda is the promotion of health tourism in India. Wellness is one of the prominent attributes of human health, as recognized in the World Health Organization's (WHO) definition: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1978). The wellness approach has initiated a process of globalization which can be seen and used as an opportunity for the innovation and modernization of leisure and health resorts, spas, and tourism destinations (Nahrstedt, 2004:181). Asian systems of medicine such as ayurveda, yoga, etc., are recognized as promoting the wellness aspect of health and containing the seeds of the concepts of health and wellnesses. Over the last few decades some resorts in India and abroad have been offering comprehensive wellness packages within an ayurvedic health tourism for both domestic and overseas clients. It could be seen as influence of globalization and new age commodification of ayurveda.

Nahrstedt described wellness as "a way of life or lifestyle that an individual create to achieve own highest potential for well-being while achieving a high level of wellness involves continual striving for a more healthful way of living" (Nahrstedt, 2004:184). The concept of well-being requires initiative and determination, everyone deciding for himself or herself whether to make a lifestyle change (Schobersberger et al., 2004:200). Wellness involves physical activity combined with relaxation of the mind and intellectual stimulus - basically a kind of fitness of body, mind, and spirit (Schobersberger et al., 2004:199-200). There are two major aspects of wellness; the physical aspect and the spiritual aspect. The physical aspect emphasizes exercise or fitness, dietary practice, behavioural motivation, and environmental surroundings –

what is called ‘lifestyle change’, or rectification (*shonsodhon*) in ayurveda. The spiritual element of wellness consists of purification and revitalization of mind and soul. Nahrstedt further considers wellness as a product of the knowledge society, and the knowledge society has significantly increased understanding of the relationship between illness and health (Nahrstedt, 2004:184). Apart from physical fitness and spiritual purification, good nutrition, beauty, relaxation, mental activity, social harmony, and environmental sensitivity are also important element to achieve a high level of wellness (Nahrstedt, 2004:185).

Wellness and health tourism became complementary during the era of globalization, as most of the wellness activities persist under the health tourism scheme. Laws define health tourism “as leisure taken away from home, where one of the objectives is to improve one’s state of health” (Laws, 1996:199). Health tourism can be relate to various physical or psychological subcategories, such as medical check-ups, beauty treatments, specialized surgery, slimness, improve fitness, diet, etc. (Laws, 1996:199). Laws further perceived health and tourism as partners in market development over the last few decades (Laws, 1996:200).

Selby examines how the proponents of the Euro-American New Age have transformed early ayurvedic ideas about women’s health into an essential segment of the modern wellness industry, and medicine is transformed into wellness (Selby, 2005:120). She shows that ‘Vedic’ is used as a brand name, as “American spa culture is offering a package of panchakarma treatments that include, oil massage, herbal steam treatments, shirodhara, cleansing diet, herbal therapy, lifestyle education, and other therapies” (Selby, 2005:121). Beauty and women become prime consumer

targets for the recent development of wellness and spa culture, and middle class professionals are the clients buying alternative health service packages provided by the wellness centres. Ayurveda has been transformed into a commodity instead of a method for restoring health. New age consumers are by and large female (Selby, 2005: 129-130). Nahrstedt points out that 'fitness' was originally oriented toward young men, while wellness was first accepted by young women (Nahrstedt, 2004:185). Both cases recognize a dramatic entry of women into ayurvedic consumerism, which is contrary to classical ayurvedic practice: there is very little evidence of women's access to ayurveda as either practitioners or consumers in the past.

Methodology

This research is based on a qualitative study approach. In addition to empirical data collected through fieldwork, locally available documents have been screened for any related information. Some quantitative data has also been explored and utilized. Secondary sources were utilized to substantiate field data. The field work was conducted in Calcutta, the capital of West-Bengal, located in the eastern part of India. Calcutta is one of the oldest and most historically important cities founded during the early stage of British colonial rule, in the eighteenth century. It was also the capital of the British India until the early twentieth century.

The major reason for choosing Calcutta is my language advantage. It is a city habited predominantly by the Bangla-speaking ethno-linguistic group to which I belong. Apart from visiting individual respondents' houses in different locations, I conducted participant observation in Raja Bazar Dabur Ayurvedic Medicine Shop[4]; J

[4] Dabur Ayurvedic Medicine Shop is not a retailer operated by Dabur India Limited. It is a privately-

B Roy State Ayurvedic College and Hospital in Raja Dinendro Street; Gray Street, which is popular for the locality of ayurvedic *kabirajes*; Tarok Chaterjee Lane; Central Research Institute (Ayurveda) in Salt Lake; Vedic Village in Rajer Hat; Bhawanipore Ayurvedic Databya Ausadhalaya in Ashutosh Mukherjee Road; and Baidyanath Ayurvedic store in Bondel Road. Different forms and conditions of ayurvedic practice co-exist in Calcutta. Most needy people visit the public hospital, and I chose the Central Research Institute (Ayurveda). Middle class patients usually go to private practitioners or *kabirajes*. Wealthy patients and client visit Vedic Village, a recently-built ayurvedic tourist resort and spa in Rajer hat. Ayurvedic drug stores are scattered in various locations of the city. I chose two drug stores representative of reputed ayurvedic companies in India: Dabur and Baidyanath. The fieldwork was completed in two phases during August-September 2004 and July-September 2005.

Data collection techniques

The major data collection techniques for primary data gathering employed in this research are: survey, individual interview with semi-structured questionnaire, observation, and participant observation. Secondary data from electronic and print media and ayurvedic classical texts and photographs were also collected. I got verbal permission from interview respondents for use of individual photos. To understand the institutional foundations of ayurveda, the Central Research Institute (Ayurveda), J B Roy State Ayurvedic College and Hospital, Dabur Ayurvedic Medicine Shop and Vedic Village were selected for the following reasons: the Central Research Institute is the only public funded research institute in West Bengal doing clinical research on ayurveda and having a hospital unit. A relatively underprivileged community seek

own shop exhibiting the sign 'Dabur Ayurvedic Medicine".

medical help from this institute because of government subsidy and the low cost of treatments. J B Roy State Ayurvedic College and Hospital is the only public funded college for undergraduate ayurvedic education in West Bengal. Dabur is one of the biggest drug manufacturers in India, and Dabur Ayurvedic Medicine Shop sell ayurvedic drugs mostly, but not exclusively, from Dabur India Limited. Vedic Village is a resort where wealthy Indian and overseas clients take part in ayurvedic wellness programs. Since Calcutta has a stratified society, the selection of the above four institutions provided a complete scenario of ayurvedic practice in Calcutta, for all social classes. It also allowed for the investigation of the modernization of ayurveda in terms of education and research and the global commodification under the health tourism program in the Vedic Village. Baidyanath Ayurvedic Shop and Bhawanipore Ayurvedic Databya Ausadhalaya, a charity organization providing ayurvedic treatment, were also selected to provide greater understanding of the reality in ayurveda and its commodification process. Leaflets, flyers, therapeutic indexes annul reports, and record books of patient admission were also collected. Data from different sources, including the government, were gathered to supplement the primary data. Some surveys among patients and customers were done with a pre-prepared questionnaire at the Dabur Ayurvedic Medicine Shop, Baidyanath Ayurvedic Shop, Bhawanipore Ayurvedic Databya Ausadhalaya and Tarok Chaterjee Lane. Five different questionnaires were utilized, with many common questions. Thematic content analysis of the classical ayurvedic texts *Charok Samhita, Susrut Samhita and Ashtangahridaya* were done to gain deeper understanding of the ongoing practice of ayurveda.

Sampling

Five categories of respondents were selected for interview: patients (40), ayurvedic practitioners (20), ayurvedic undergraduate students (20), ayurvedic Kabirajes (10), and 4 overseas patients and clients from the Vedic Village, for a total of 94 interview respondents. Out of the 40 patients, 20 were from public ayurvedic hospital and came from relatively low socio-economic groups; 20 from private practitioners' chambers came from relatively affluent socio-economic backgrounds. An equal number of male and female patients were chosen for this research. A total of 5 months fieldwork was conducted in 2 phases, August-September 2004 and July-September 2005.

During the first phase of fieldwork, in August-September 2004, all the respondents were selected by purposive sampling. Many patients and physicians were asked randomly for interviews, and only those willing were interviewed. The sample size during this phase was 20 patients from public hospital and 15 physicians from different institutions.

During the second phase of fieldwork, from July-September 2005, a survey among 55 patients who visited private ayurvedic practitioners (including physicians and *kabirajes*) was conducted. 20 respondents out of the 55 were intensively interviewed, with a balance of males and females. All survey respondents were asked to sit for intensive interviews. However, some did not agree due to time constraints, and 20 among the willing patients were selected randomly. Prior interview appointments were made and most of the interviews were conducted at the patients' houses or preferred places such as offices etc. A few interviews were also carried out in the waiting rooms of physicians' chambers, especially among those patients who

came from outside Calcutta. All the *kabirajes* and students were interviewed during the second phase of fieldwork. *Kabirajes* of at least 2 generations were selected according to their family traditions and reputations. A survey was also carried in the Dabur Ayurvedic Medicine Shop on the consumption patterns of the consumers and the best-selling products for about 7 working days among 205 customers (134 from the first phase and 71 from the second phase of field work).

Content analysis was another research tool applied in this study to generate data. This included content analysis of classical ayurvedic texts, popular magazines and television advertisements. Three classical ayurvedic texts were selected for analysis: *Charok* and *Susrut Samhita,* which are the most popular classical texts used in the eastern part of India, and *Ashtangahridaya,* which is extensively used in Southern India. Relevant chapters of the above texts have been analysed in various sections of this dissertation to support the arguments. Concerning magazines, three of the most popular magazines published in Calcutta in Bangla language were chosen, and only *Puga* issues (Puga is the biggest religious festival for the Hindu community) for 1411 (2004) were analysed. These magazines are *Anand Bazar*, *Anand Mela* and *Desh Patrika*. Only ayurvedic/natural and herbal products advertisements published in these magazines were selected, and their contents were analysed. Apart from this, advertisements of WWS Company manufactured ayurvedic products broadcast on the Bangla television channel were chosen for content analysis because of the fact that it spent large amount of time for advertisement.

Data analysis techniques

I relied on manual coding for qualitative analysis, with respondents representing various categories and sample size being moderate. I used the Microsoft excel program for quantitative analysis. Content analysis of the media was also carried out. Methodological triangulation was used to analyse various data sets.

Outline of chapters

This dissertation consists of eight chapters. Chapter One deals with the conceptual overview and methodological devices. Chapter Two focused on the Vedic origin of ayurveda and its Hindu connection. Chapter Three emphasizes the colonial and post-colonial state intervention in ayurveda, especially looking at the dispute between colonial subjugation and post-colonial revival. Chapter Four analyzes the use of ayurvedic medicine in modern Indian society. This chapter particularly examines the city of Calcutta, the capital of British India until the beginning of the twentieth century.

Ayurvedic education in India is a site of discrepancy between Westernization and indigenization. Chapter Five looks at the professionalization of ayurveda in modern India and argues that modern ayurvedic education and research reproduce colonial hegemony and inheritances.

The commidification of ayurvedic health products especially for middle class consumers is a new trend developed over the last few decades. The content of ayurveda has been shifted from 'medical account' to 'natural product' because of global commodification. Many of the biggest national and trans-national drug manufacturers have participated in this shift. The entry of women as ayurvedic health

products' consumers is another trend developed over the last decades, and the 'female body' has been transformed to a 'natural body'. Chapter Six looked at the ambiguity of ayurvedic commodification.

There is a 'New Age Orientalism' emerging in ayurveda during the era of globalization. Chapter Seven examines the recent development of 'ayurvedic wellness and spa culture' across India, which has targeted the middle class professional and wealthy entrepreneur as clients. It analysed how the Vedic content of healthy life is repackaged by ayurvedic tourist resorts and wellness centers for rejuvenation and relaxation. Chapter Eight contains the summary and conclusion of this dissertation.

Chapter Two

The Vedic origin of ayurveda

Introduction

More than a million square kilometers of prehistoric Indus civilization in Harappa, Mohenjo-Daro, Chanhudaro, Lothal and Kalibangan cities contain the seeds of the Indian medical heritage. Archaeological discoveries have revealed sophisticated drainage systems and several communal baths with an effective water supply system that represent the efficient sanitation system of the city of Mohenjo-Daro. Public health was highly regarded and hygiene was prioritized in the Harappa culture. The Harappan 'Great Bath' is still considered a cornerstone in the study of the development of international public health. However, the later development of prehistoric medical practice in the Indus valley region is rather ambiguous. About 1500 B. C. the light-skinned Aryans[5] who invaded/migrated into India represented a new phase of medical development through introducing and developing a systematic medicine and health tradition known as 'ayurveda'.

The objective of this chapter is to provide an understanding of the philosophical and historical contextual overview of ayurveda. In particular, this chapter spells out the Vedic origin of ayurveda, its systematic development as a complete medical system, major concepts used in ayurveda to perceive cosmic

[5] There are several homeland proposed by the scholars about the Aryan community, Persia or Indo-Europe or Central Asia or even Eastern Europe

elements of health, diagnostic principles, and the fundamental ideals of maintaining vigour and vitality. In addition to this philosophical understanding, this chapter explores ayurveda's relationship with religion, Hinduism in particular, but also the influence of other religions such as Buddhism and Islam.

Origin of the Vedic medical tradition (ayurveda)

The Aryans authored literary compositions, known as Vedas although the knowledge they contain was orally transmitted for a long time. There are four Vedas - the *Rig-Veda, Yajurveda, Sam Veda, and Atharvaveda* - among which the Atharvaveda in particular pertains to medical knowledge. According to Subbarayappa, "the Vedic pantheon was an extensive ensemble of divinities, and gods were also invoked for curing diseases" (Subbarayappa, 2001:10). Plants, gods and animals became inseparable in the healing process of Vedic medicine, and many priests came as healers.

Numerous scholarly researches mention the various origins of Vedic medicine. One of the pioneers of this development is God. In an earlier study, Mukhopadhyaya viewed the gods as prime movers in Vedic medical heritage, and many passages in the Vedas praise the power of the gods (Mukhopadhyaya, 1922-29:67). Mukhopadhyaya wrote that "in the prior epochs of the Vedas only universal deities were, more or less, related to medicine and disease - such as the *Asvins, Rudra* and other gods although later on there were deities with definitely medical functions, or pest-gods" (Mukhopadhyaya, 1922-29:67). The Vedic gods were of three categories: celestial, aerial and terrestrial, each governed by one of the three principal gods; *Surya, Bayu* or *Indra, and Agni,* respectively (Roy, 2001:43). The Vedic hymns also recognize the

prominence of gods as healers. Mukhopadhyaya concluded that “it is from God that the physician derives his light - it is to Him he calls for succour” (Mukhopadhyaya, 1922-29:67-68).

Another possible origin of Vedic medicine is from animals. In the several parts of the Vedas it is found that medical knowledge was often derived from the actions of animals. Various animals such as boars, serpents, eagles, falcons and birds, oxen, goats, sheep; and some other, wild, animals got especial attention and acted as teachers of medicine (Mukhopadhyaya, 1922-29:72). At the time of of the Macedonian (Greek) Alexander the Great’s invasion of India (327 B.C.) animal substances played an important role in Vedic medicine - especially snakes. While Alexander the Great’s army physicians were not aware of the cure for snakebites and some other health problems endemic to the area, and native Indian practitioners were called in, some of whom later accompanied the returning army back to Greece (Paramesh, 2001:519).

Apart from gods and animals, plants were also substantial agents in early Vedic medicine. The settlements referred to in the Vedas were confined to the lush green regions of the rivers in the northwestern part of India (Subbarayappa, 2001:10). The surrounding natural environment and the variety of flora caused the emergence of a symbiotic relationship between the people of Vedic times - especially the priestly class or healers - and the plant kingdom (Subbarayappa, 2001:10). Whenever these communities suffered from diseases they looked to the accessible plants for the alleviation of their diseases. Roy wrote that “the cult of *Soma* in Vedic livelihood is essentially the cult of vegetation, and *Soma* was the appellation of the Lord of Herbs”

(Roy, 2001:44). Plants also helped to keep the environment cool and pollution-free, along with water and air (Roy, 2001:44).

Ayurveda and its systematic development

Ayurveda is the systematisation of the Vedic medical knowledge and healing practices that were present during the Vedic era. The word *ayurveda* consists of two Sanskrit terms: 'veda' means 'knowledge' or 'science', while 'ayu', means 'life' or 'duration of life'. *Ayurveda* thus refers to the knowledge of life or the science of life. Ayurveda defines *ayu*, or life, as a combination and coordination of four parts: *atta* (the soul), *mona* (the mind), *indrio* (the senses) and *sharer* (the body) (Joshi, 1997). Each of these parts has a specific function in maintaining the balance of the body (Joshi, 1997:15). Whenever there is a disconnection among these four elements an immediate physical, mental or spiritual imbalance arises.

The sacred scriptures, the *Vedas*, reflect a total worldview that includes aspects of creation, metaphysics, philosophy, ethics, religion, magic, medicine, dietary rules, and guidelines for the activities of daily living (Ninivaggi, 2001:7). According to Ninivaggi, The guardians of the *Vedas* were the priestly category of Brahmins, who represent the top cluster (*varna)* of castes in the the caste hierarchy introduced by the Aryans; and the "Brahmanic tradition is virtually synonymous with the Vedic tradition" (Ninivaggi, 2001: 8).

The most famous two classical ayurvedic epics, the *Charok Samhita* and the *Susrut Samhita*, were written in Sanskrit and are part of the Brahmanic tradition. The Sanskrit word *samhita* means 'compendium', and Charok and Susrut are the proper

names of the authors - thus these titles may be translated as ‘Charok’s Compendium’ and ‘Susruta’s Compendium’ (Wujastyk, 1995). It has been stated in the *sutro sthan* of the *Charok Samhita* text that Agnivesh was the best of Atreya’s students and that he documented his “preceptor’s methodological exposition” and prepared a text under the title *Agnivesa Tantra,* which is another name for the *Charok Samhita* (Subbarayappa, 2001:14).

The ayurvedic compendium is also called the *astango* ayurved. It consists of eight branches: *Salya tantro* (surgery), *Salakya tantro* (ophthalmology), *Kaya chikitsha* (internal medicine), *Bhuta bidya* (psychiatry and demonology), *Kaumarabrithya* (paediatrics, obstetrics and gynaecology), *Agada tantra* (toxicology), *Rasayana* (rejuvenation), and *Vajikarana* (virilisation) (Susrut, sutro sthan, chapter 1, paragraph 3). The *Susrut Samhita* designated the importance of the above eight branches, as follows:

> 1.The *Salya tantro* describes the tactics and procedures to recover from wounds, burns, cuts, surgical amenities, etc. If any grass, wood, stone, dust, iron, bone, hair, nail, rock, etc. enters any parts of the body, the *Salya tantro* explains the surgical procedure to bring it out and restore health. It also deals with the wounded parts of the body and prenatal issues. Machines, sharp knives, acid and fire are used in the *Salya tantro*.
>
> 2. The *Salakya tantro* deals with ear, eye, mouth and nose related diseases
>
> 3. The *Kaya chikitsha* discusses fever, diarrhoea, mental disorder, skin disease, leprosy, etc.
>
> 4. The *Bhutabidya* deals with the mental and spiritual peace of the patients. When someone loses his/her mental and spiritual balance - because of the influence of demons, giants, deities, gods; or, divine, celestial or natural spirits; or cannibalism;

etc. - the *Bhutabidya* prescribes possible tactics to restore mental and spiritual health; and sacrifices (e.g., of. animals, etc.) for the sake of the planet and nature.

5. Child caring, purification of breastfeeding, pollution of the breast and childhood diseases caused by the misallignments of the planets and/or natural calamities are handled in the *Kaumarabrithya*.

6. The *Agada tantro* explains illness due to snake bite, poisoning, insects, spiders, scorpions, etc., and suggests the possible methods to recover ffrom these physical injuries.

7. The *Rasayana* explains how to protect from unwanted aging, how to enhance intellectuality and knowledge, how to boost the spirit and physical strength, and how to deal with chronic diseases.

8. The *Vajikarana* analyzes the increase of sperm count for men, the purification of polluted sperm, sexual ejaculation, sexual competence and sperm reproduction, and how to enhance the strength of men (Susrut, sutro sthan, chapter 1, and paragraph 4-11)

The *Charok Samhita* consists of 87 chapters divided into 6 major *sthans* (areas of treatment), while the *Susrut Samhita* consisting of 186 chapters dealing with 6 major areas of health. The 6 *sthans* of the *Charok Samhita* includes *sutra sthans* (principles), 30 chapters; *nidan sthans* (etiology, symptomatology and pathology of a few diseases), 8 chapters; *biman sthans* (specific measures of standardisation, quantification and its application), 8 chapters, *sharir sthans* (human physiology), 8 chapters; *indrio sthans* (organs of sense), 12 chapters; and *chikitsha sthans* (therapeutics), 21 chapters. The 6 major areas of health presented in the *Susrut Samhita* are *sutra sthans* (origin of Veda, fundamental principles of surgery and surgical instruments, seasonal practices, dietary regulations, rectification, etc.), 46 chapters; *nidan sthans* (major diseases and disorders where surgical or para surgical

interventions are found necessary), 16 chapters; *sharir sthans* (postulates of the origin of the universe, embryology, anatomy, physiology, mother and child care, study of veins, reproductive health, etc.), 10 chapters; *chikitsha sthans* (management of several specific diseases, leprosy, arthritis, etc., and general therapeutics or measures of internal medicine), 40 chapters; *kalpa sthans* (animate, inanimate and artificial poisons of snakes, insects, etc., and their management), 8 chapters; and finally *uttar tantra* (ophthalmology, ear, nose, head, spiritual cures, eyes, sex, diarrhoea, heart disease, epilepsy, bronchial asthma, hiccough, parasite, urinary problems, etc., and their treatments), 66 chapters (*Charok* and *Susrut*, content[6]; Gopinath, 2001: 60-62)[7].

Major concepts, diagnostic methods and characteristics of ayurveda

According to ayurvedic thought, the human being is a creation of *panchamabhuta* (five cosmic elements: space, air, fire, water and earth) and *atta* (soul). While humans are the highest of living species, and they are the most adept beings at understanding and curing diseases (Susrut, sutro sthans, chapter 1, paragraph 18). The *panchamabhuta* are considered the basic building blocks of nature, responsible for all physical existence. Another powerful conceptual tool in ayurveda is that of the three *dosha* (humour). The five elements of *panchamabhuta* have different impacts on *dosha* because of their changing natures according to time and season (Joshi, 1997:8-9). The concept of *dosha* includes two fundamental ideas: firstly, its being a bioenergetic substance; and secondly, its action as a bioenergetic

[6] I counted the number of chapters from the content section of the Charok and Susrut Samhita texts

[7] Because of my limited knowledge of Sanskrit, I have read the Bangla translation and edition of Charok and Susrut Samhita. Charok by Kabiraj Brojendra Chandra Nag; Susrut was also translated by Joshadanando Sarker and edited by Baidyacharjo Kalikinkor Sensharma and Ayurvedacharjo Shatoshakhor Bhaitacharjo.

regulatory physiological force, process, or principle (Ninivaggi, 2001:47). According to the *Charok Samhita*, "all the physiological diseases are originated and caused by the alteration of *vata-pitta-kapha* or the functional capacity of *dosha"* (*Charok*, sutro sthan, chapter 1). As a result, if the equilibrium of the *dosha* is maintained, the disease cannot take place in the body. The *Charok Samhita* also recognizes that physiological disorders should be cured by taking *zuktighotito oushad* (logical medicine) and engaging in *daibo karmo* (spiritual activities); and all mental disorders should be cured through applying *gana* (knowledge), *biggan* (science), *dharjo* (patience), *sriti* (memory), etc. (*Charok*, sutro sthan, chapter 1, paragraph 3). The medicines described in the *Charok* and the *Susrut Samhita* contains a broad array of animal, vegetable and mineral substances.

Another important idea in ayurvedic thought is that of *prakriti* (nature). The idea of *prakriti* is that "each human being is born with a unique combination of the three doshas, and that this natural balance is what is responsible for the physical, mental and emotional differences among people" (Joshi, 1997:9). An intimate relationship between the individual human being and all aspects of his/her environment is another foundation stone of ayurveda (Joshi, 1997:9). *Ritucharya* (seasonal practices) have an important role on human health and all the changes in climatic conditions impact on health. When a seasonal change brings a shift in wind conditions, air temperature, humidity and/or rainfall, it will impact the balance of the doshas within human bodies (Joshi, 1997:9).

Ayurvedic diagnostic methods are divided into two broad types: the examination of the patient and the diagnosis of disease. The patient is not considered

only as a case of disease but also as an individual human being with all his/her attributes, such as lifecycle, family history, genetic substance, lifestyle, body building mechanism, quality of tissue, age, sex, dietary habit, mental condition, digestive power, etc. (Kurup, 2002). There are two basic principles of ayurvedic treatment. Firstly, *samanya* (like increases like), which relates to the interconnectedness of all aspects of the world and the claim that "factors, substances, qualities, or attributes of a specific type exert similar effects on the object to which they are applied" (Ninivaggi, 2001: 38). Another principle of ayurvedic treatment is called *vishesha* (opposites balance and so cure each other), which relates to the idea of balance and imbalance (Ninivaggi, 2001: 38).

It is mentioned in the *Susrut Samhita* that ayurveda has two purposes: firstly, to cure patients; and secondly, to maintain the health of healthy persons. The text also recognizes that the body and the mind are the two complementary constituents of a living being and the sources of disease: some diseases emerge from the body, others from the mind, and a few are both from the body and mind (*Susrut*, sutro sthan, chapter 1, paragraph 20). The *Charok Samhita* further denotes that mind, soul, and body are as similar as the three legs of a table. Human life depends on the combination of mind, soul and body. Human pain, pleasure, activity, knowledge - everything depends on the balance of mind, soul, and body (*Charok*, sutro sthan, chapter 1, paragraph 1-4). According to Frawley, "ayurveda views the physical body as a crystallization of deep-seated mental tendencies and regards the mind as the reflection of the body and the storehouse of the impressions we access through the senses" (Frawley, 1997:4). In ayurvedic thought, disease is considered as a pool of acts or events that cause human sufferings. The *Susrut Samhita* categorizes the causes

of disease into four types. *Agunto* (sudden) diseases are caused by external strikes (an arrow for instance). Physical diseases are related to dietary habits and are caused by inappropriate food habits: because of inappropriate dietary habits, bile, blood, air and phlegm in the body mislead, causing physical diseases. Mental diseases are generally caused by anger and hate, but also by jealousy, fear, sadness, greed, sex, poverty, excitement, sorrow, etc. Finally, normal diseases are caused by hunger, thirst, lack of sleep, etc. (*Susrut*, sutro sthan, chapter 1, paragraph 20). Concerning modes of curing, the *Susrut Samhita* suggests four means, namely: cleansing/purification, correction, dietary change and, behaviour motivation (*Susrut*, sutro sthan, chapter 1, paragraph 21).

Constituents, actors and ideals of ayurveda

One of the frontline foundational constituents in ayurvedic tradition for maintaining health is food, as human body strength, colour, and sickness are caused by food and dietary habits. The *Susrut Samhita* categorises the medicines related to foods according to two types, plant-based and animal-based. Plants are of various types: *banaspoti* (those plants that produce only fruits but do not produce any flowers), *brikho* (those trees that produce both flowers and fruits), and *oshodhi* (those plants that die after their fruits have ripened) (*Susrut;* sutro sthan, chapter 1, paragraph 22). Simultaneously, animals are categorised in the *Susrut Samhita* under four genus: *jaraus* (animal and human); *andos* (birds, snakes, and other reptiles); *shabdos* (ants and other insects); and *udvijo* (those animals that eat plants and grass) (*Susrut*; sutro sthan, chapter 1, Paragraph 23). Gold, silver, diamond, soil, etc., are considered materials elements; while wind, winter, dark, hot, cold, months, seasons, rain, etc., are considered seasonal elements. The different material and seasonal elements have

different impacts on the enlargement, reduction, and recovery of *bayu-pitto-kapha* and are very essential elements for health (*Susrut*; sutro sthan, chapter 1, paragraph 24). A classification model consisting of 10 pairs of opposites is used in ayurveda for conceptualization. These are: "*shita/ushna* (cold/hot), *snigdha/ruksha* (wet/dry), *guru/laghu* (heavy/light), *sthula/sukshma* (gross/subtle), *sandra/drava* (dense/liquid), *sthira/chala* (stable/mobile), *manda/tikshna* (dull/sharp), *mridu/kathina* (soft/hard), *slakshna/khara* (smooth/rough), and *picchina/sishada* (sticky/clear)" (Ninivaggi, 2001: 39). Usually foods and herbal substances are understood in this way, and the classifications are associated with both material substances and psychological processes.

Another player in the ayurvedic arena is the practitioner or *vaidya*. Ancient tradition demanded that a physician should be truly a friend, philosopher and guide, in both the spiritual and material life of the sick person who approaches him for the cure to his disease (Gopinath, 2001:62-63). The *Susrut Samhita* describes the terms and conditions for selecting a student to become a *vaidya*. According to the *Susrut Samhita* text:

> "A *guru* (master) must select a junior physician or *shisho* (student) from *Brahman, Khatrio or Vaisho* castes. The student should have good family background; be young in age, and strong, polite, intelligent, and meritorious; and have a powerful memory. His tongue, cheeks and teeth should be narrow. His mouth, eyes and nose should be *sharol* (straight). He must have strength to bear hard work" (*Susrut*, sutro sthan, chapter 2, paragraph 2).

After selecting a student a *guru* (master) should ask the student to recite a *montro* (hymn) in the presence of fire. The *montro* spells out that:

> "The student should avoid *kam* (excitement), greed, anger, arrogance, jealousy, cruel words, lies, etc. He should cut his nails and hair regularly and stay clean and purified, wear decent dress and be fond of truth (*shatobroto*). He should be a follower of Brahman, and courteous. He should not visit any place without the permission of his master. He should follow his master in how to sleep, sit, eat and study. Disobedience of these rules may cause damage for the student's professional career and make him unsuccessful in achieving the fame of a famous *vaidya*" (*Susrut*, sutro sthan, chapter 2, paragraph 4).

Simultaneously, a master should be vigilant, to ensure that the student obeys all the rules and regulations in order to avoid misunderstandings that might result in conflicts and tensions between the disciple and himself (*Susrut*; sutro sthan, chapter 1, paragraph 4). Many humanistic and moral suggestions are also provided by the *Susrut Samhita*. For instance, "a physician should treat the poor, the teacher and the refugee the same as a member of his own family, and treat them with his own medicine" (*Susrut;* sutro sthan, chapter 1, paragraph 5). The *Charok Samhita* also acknowledges that a *vaidya* should have four major qualities. Firstly, he should have sound knowledge of the subject matter. Secondly, he should observe the treatment of many patients and be acquainted with expertise by watching the treatment procedures of many famous physicians. Thirdly, he should gain sufficient skill in treatment methods and procedures. Finally, he should be self-purified and spiritual (*Charok*, sutro sthan, chapter 9, paragraph 5).

In addition, ayurveda emphasizes the ideals of human life and the importance of health. There are four basic life goals or prime values for each individual. These are: *dharma* (ideals), *artha* (money or material accumulation), *kam* (pleasure, excitement, sex), and *mokthi* (liberation) (Ninivaggi, 2001:37). All these four life goals indicate that moral and ideological values were highly regarded in ayurveda.

The Hindu origin of ayurveda

In the following section the origin of ayurveda's Hindu connection will be investigated from three perspectives. Firstly, an exploration into the ayurvedic classical texts *Charo*k and *Susrut Samhita* will be made, to unfold the religious and divine nature of ayurveda. Secondly, an understanding of how ayurveda corresponds to the Hindu caste affiliations will be made. Thirdly, an investigation of the relationship between food and dietary practice in the Hindu faith and in ayurveda will be made, as food and dietary regulation for the maintenance of health and illness constitute an important feature of ayurvedic treatment.

Ayurveda and Hinduism

Fields illustrated four principal dimensions of religious therapeutics: "religious meanings that inform philosophy of health and medicine; religious means of healing; health as a support to religious life; and finally religiousness itself as a remedy for the suffering of the human condition" (Fields, 2001:1-2). Since the medical concepts of ayurveda can be found in the religious ideology of Hinduism, Fields considers ayurveda as a religious therapy (Fields, 2001: 79). Hinduism is the European given name for the Sanatan Dharma, a particular form of religious orientation practiced in India. Ayurveda is also called *Sanatan Dharma Pathy* by many orthodox Hindus in modern India.

There are several themes in the analysis of the medical and religious elements of Hindu medicine. Firstly, spirituality, which represents a major dimension in keeping and maintaining health and balancing the mind-body complex (Fields, 2001:78). For example, the Hindu god Ganesh is popular for his knowledge, and is

the remover of obstacles. He is worshipped, or at least remembered, at the beginning of any auspicious performance, and many ayurvedic *kabirajes* and health centers have his picture hung as a symbolic representation of the faith. There is a myth that divine ayurvedic physicians conducted surgery and placed an elephant head on Ganesh's shoulders, which empower him with knowledge and intelligence. Apart from this myth, there is also a scholarly religious attempt to connect Lord Ganesh with ayurvedic practice, and some ayurvedic *kabirajes* worship Ganesh before attending to a patient in order to enhance healing power and spirituality.



P 2.1-2.2 - The Hindu god Gonesh, with his elephant head

Source: Photos were taken by the author from Baidyanath ayurved literature and the Vedic Village during participant observation.

The Aryans in India produced both the Vedas and Hinduism, and this grounded the seed of ayurveda's connection with Hinduism. The *Rigveda* is the oldest among the Vedas. The medical phase of Vedic life in the Aryan community was written in the *Rigveda* and the *Atharboveda* and both the texts are considered as the foundation blocks of ayurveda. There is substantiation to prove ayurveda's religious connection in both the *Charok* and *Susrut Samhita* texts: firstly**,** godly characters are present in

both the texts. The *Charok Samhita* delineates that the appearance of various diseases causes inconvenience for human worship, learning, theology and vows, and also causes starvation. Many sages - including Ongira, Zomodagni, Bashishosto, Kashsopo, Vrindo, Atrinandon, Punorbasu, Shanko, Gautom, Pulosto, Narod, Asitt, Agosto, Bamdeb Markendeo, Ashaloin, Atuinondon Bhique Parikhi, Kopingol, Vorodaz, Bishamitro, Ashorakho, Vargob, Chabon, Avigit, Gargo, Shandillo, Kondillo Bakhi, Thabol, Galob, Shankristo, Bayjibapi, Kushik, Badraon, Borish, Shorloma, Kappo, Kattaion, Kankaon, Kaikoshay, Thaumo, Marichi, Kashap, Sharkorakho, Hironak, Lokhako, Painghi, Shaunik, Shakuney, Moytrai, Maynotayoni, Anekhanek Baykhanos and Balkhillo, etc. - gathered at the foot of the Himalaya to get rid from various diseases and asked God to enlighten them. Moharshi Vorodag was selected to visit Lord Indra's house and find the route to escape from illness (*Charok*, Surto sthan, chapter 1, paragraph 1). Later Moharshi Vorodag moved into Lord Indra's house and acquired knowledge of ayurveda, and then shared it with others. He taught his six followers - Agnibesh, Vel, Jatukorno, Parashoto, Harit, and Kharpani. Agnibesh was the most intelligent of these and authored a book, the *Agnibesh Tantro*, which was approved by the councillors[8] and was established as a system of healing (*Charok*, sutro sthan, chapter 1, paragraph 3).

As for the second theme, the *Charok Samhita* compares the qualities of noble physicians with those of the Brahmins, the priests of Hinduism. In the text, a *vaidya* (physician) was given a position superior to that of a Brahmin. The *Charok Samhita* text states that "an intelligent and logical chancellor will be adored as a preceptor by the human being who is called a Brahmin. The Brahmin is twice born, but the *vaidya*

[8] Here councillor refers the knowledgeable persons of that time which is called '*biggojon*' in Bangla

is thrice born; while the title *vaidya* is not acquainted by birth. If the Brahmin learns the Vedas and attains knowledge of medicine and medication he can be treated as a *vaidya"* (*Charok*, chikitsha sthan, chapter 1, paragraph 1). The idealistic character of a *vaidya* is presented in the *Charok Samhita*, where "a real physician should be knowledgeable about scripture, medication, the treatment philosophy, and the economics of health" (*Charok*, sutro stahan, chapter 9, paragraph 5). Not only skill in medicine and medication, but also self-purification and knowledge of scriptures and other social qualities are key determinants for the success of a *vaidya*, the *Charok* emphasises.

The third theme, faith in the next life or re-birth or reincarnation, is a vital part of Hinduism. The *Charok* promotes the belief in the next life and states that, "every human in this universe should care about three major issues: health (*pran*), wealth and the next life (*porolok*)" (*Charok*, sutro sthan, chapter 11, paragraph 3). The *Charok Samhita* text again states that "the atheist who believes that there is no god, no reason behind our acts, no sage, no next life, and no result of our activities, no soul; and that everything happens, borns and dies according to a natural process; are sinful and are suggested to avoid atheism and follow the lifestyle and suggestions of the sages" (*Charok*, sutro sthan, chapter 11, paragraph 3). Charok described the positive qualities of a pious person who puts faith in religion, and these qualities are connected with Brahmanism. Charok further states that "the diligent persons who have faith in religion and are truly free from fear, anger, and greed can observe second born " and that it is wise to believe in the truths of the second birth (*Charok*, sutro sthan, chapter 11, paragraph 1).

The final theme in the *Charok* is the careful recognition of the superiority of the Brahmin as an ayurvedic practitioner, and states that ayurveda should be studied by the Brahmin, Kshatriya and Vaisya castes - the Brahmin would study ayurveda for scholarship, the Kshatriya for self-defence and the Vaisya for prosperity, and to maintain their own Dharma (ideal), Ortha (wealth) and Kama (sex) (*Charok*, sutro sthan, chapter 30, paragraph 2). The text further furnishes that "a knowledgeable and ideal person can achieve Dharma if he takes good care of his parents, siblings, friends and seniors during their sickness and gives advice according to ayurveda" (*Charok*, sutro sthan, chapter 30, paragraph 2). The text further documented that, as Ashiwinikumaras (the physicians of goddesses) treated the broken teeth, eyes and arms of different gods, they were appreciated and worshiped by Lord Indra. Subsequently, Lord Indra hosted the breakfast for the Ashiwinikumaras in the garden of paradise (*nando kanon*) (*Charok*, chikitsha sthan, chapter 1, paragraph 3).

Despite the enormous evidence showing ayurveda's connection with religion, some scholars have found paradoxical elements between the practice of ayurveda and the beliefs of Hinduism. Zysk emphasises that, although religious therapeutics may include religious means of treating health problems in ayurveda, religious therapeutics embraces many other relations between healing and religiousness (Zysk, 1991). Zysk further challenges the Brahminical intellectual connection with ayurveda and argues that ayurvedic medical development was made largely by heterodox ascetics rather than by Brahmin intellectuals (Zysk, 1991). Zysk concludes that ayurvedic medical epistemology is primarily opposed to Brahminical ideology (Zysk, 1991). Bala argues that the philosophy of ayurvedic medical practice at the time was closely linked to the materialistic school of thought rather than to Brahminical religious philosophy (Bala,

1991:28). Since materialism was not favoured by Bhraminism, this school could not further develop because of the strong opposition from the Brahmanic class (Bala, 1991:28). Bala further argues that, while Brahmins managed to dominate society during both the Vedic and Post-Vedic periods, "without generating medical knowledge" they limited the further scientific development of medical practice (Bala, 1991:23). There was clear dispute between medical practitioners and religious authority in ancient India, where "religious authority disfavoured the practice of medicine by the physician" (Bala, 1991: 30). Bala concludes that the perception of ayurveda as religious therapy came much later than the practices involved in it (Bala, 1991:22).

Nichter asserts that the Brahminical influence on the practice of ayurveda in local Indian culture today is very limited (Nichter, 1996:204). He finds three trends of ayurveda which are widespread in rural India. Firstly, the response to illness by the non-Brahmin lay population of rural Indian society does not reflect a classical ayurvedic approach (Nichter, 1996:205). Secondly, "the practice of orthodox ayurveda represented in classical texts is not presently, nor has it been in recent history, a popular form of therapy available to the masses" (Nichter, 1996:205). Moreover, the systematic ayurvedic treatment written in the classical texts is not affordable for most people, is time-consuming, and is not suitable for contemporary lifestyles (Nichter, 1996:205). Thirdly, most indigenous practitioners in the rural Indian society do not understand the system of ayurveda as presented in the classical ayurvedic texts, or *samhitas* (Nichter, 1996:205).

Another ambiguity of ayurveda's connection with Hinduism is caused by the diversified practice of Hinduism in various parts of India. Tucker notes that there is diversity in the practice of Hinduism in various parts of India, and that the idea of Hindu medicine refers to only one kind of healing, connected with only one kind of Hinduism in a particular setting of Indian society (Tucker, 2003). Goddess Durga is celebrated as the biggest religious occasion by the Hindu community in Bengal, while it is not the case in South India that Hindu people celebrate the Goddess Durga with similar importance. Leslie mentions another vagueness concerning ayurveda's connection with Hinduism. He notes that modern ayurvedic practice in India is highly influenced by the unani medical system brought by the Muslims and by the allopathic system introduced by the Europeans, and is fundamentally different from the system of the classical ayurvedic texts (Leslie, 1976:356). Langford also argues that "unlike for the orientalists, for ayurvedic scholars a sincere religiosity does not in itself signal quackery, but rather tends to preclude it…..in ayurvedic history, then, science and religion are jointed" (Langford, 2002:93).

In modern Indian society, Indians are less concerned about the ideological debate that surrounds the relationship between ayurveda and Hinduism; rather, they see it as a healing system. Thus, statistics from the Central Research Institute (Ayurveda) indicate that Indians of Hindu, Muslim, Buddhist, Sikh and other religious faiths come for ayurvedic treatment. The table below denotes that the top two religious groups in West Bengal, the Hindus and the Muslims, represent respectively 72.5% and 25% of the total population, and that nearly 80% of the patients who visit the CRI are Hindus, while 17% are Muslims[9].

[9] For the patients' religious representation during 15 working days in the CRI, please see appendix 1

Table 2.1

Statistics on West Bengal's population and patient's religious representation in the CRI

Religion	Total population in W B	Patient's religion
Hindu	72.5%	80.06% (229)
Muslim	25%	16.78 (48)
Others	2.5%	3.14% (9)

Source: http://www.answers.com/topic/west-bengal and Central Research Institute (Ayurveda)

In addition, of those surveyed, 65% of the patients perceived no relationship between ayurveda and Hinduism.[10] Among the physicians, there was also a variation in views on the link between ayurveda and Hinduism.[11] One practitioner commented that:

> "Not only Hindus but also people from any religious faith choose ayurveda as a profession in recent decades. Ayurveda is a medical system and it is always neutral about religion, caste or race" (AP 16)

On the other hand, traditional *kabirajes* who have come through the apprenticeship system still perceive strong relation between ayurveda and Hinduism. Of 10 surveyed, 90% noted the Hindu character of ayurveda. One *kabiraj* commented that:

[10] Of those surveyed, 97.5% of patients were of the Hindu faith, while the other 2.5% were Muslim.

[11] Of those surveyed, 90% of practitioners were Hindu, 7.5% Muslim and 2.5% Sikh.

> "The texts of ayurveda came from Lord Siva and ayurveda originated from Lord Siva. The Indian subcontinent is called Hindustan, where the peoples of Hindu culture resided. The ayurvedic text *Charok Samhita* started with the worship of Lord Siva and there is a relation with Hindu culture by origin" (AK 7)

Ayurveda and Hindu caste

Caste is a system of social hierarchy that stratifies peoples in different categories. The status of an individual in the society is determined by the caste into which he/she was born. Caste identity is a rigid, unchangeable identity governed by hereditary, and literally confined people to occupational specialization, intra-marital relationships, etc. Literally, everyone in Hindu society is born into one or another caste and was once forced – and is still forced, in much of India today - to obey the social regulations and traditions of his/her caste. 'Caste' is a Portuguese word, used by the Portuguese as equivalent to *Varna* (a Sanskrit word, which means 'colour'). Caste hierarchy was established in India by the Aryans, and involved slavery of the Dravidians who were living in the Indus Valley region. The Aryans confined the Dravidians as Sudras (meaning slave), the lowest *varna* or category of castes. The Aryans organized themselves in three *varna* categories; Brahmins (priests), Kshatryas (warriors) and Vaishyas (traders). There was another group, called Harijans in modern India (a name given to them by Mahatma Gandhi to replace the term 'untouchable'), at the bottom of the society, who remained outside and below the Brahmins, Kshatryas, Vaishyaa and Sudras and were limited to inferior professions of the lowest social status. In order to ensure their superior status the Aryans introduced various social and religious rules which excluded the local Dravidians from any prestigious profession (Theertha, 1992:187).

In the early years many Brahminic priests became *vaidya*. This continued as a family profession over the generations. Symbolic titles were used by each family such as Dasgupta, Sengupta, etc. in Bengal, and these names indicate membership of upper castes in the social hierarchy. However, in recent years, there have been attempts to delink the ayurvedic profession with the caste system. Of those surveyed, 83% of the ayurvedic practitioners considered that there was no relation between their caste status and their professional choice to practice ayurveda.

Ayurveda, food and religion

In ayurveda, the relationship between food, religion and health features prominently. The concept of diet vs. no-diet (patto-opotto) anticipated in the *Susrut Samhita* is a core constituent of ayurveda. The *Onnopanbidhi* chapter in the text, places special importance on food and dietary habits and explains the quality and components of different cuisines for dietary regulation. The *Susrut Samhita* presents a conversation between Susrut and Lord Dhanontori in which Susrut salutes Dhanontori and asked: "My Lord! You have said that dietary intake is the secret of power for all living creatures. The growth of body and its strength depends on food intake. Recovery from disease or illness and the calm of the sense organs is also ensured by cuisine. The root cause of any ill health is inappropriate food intake. If a physician is unaware of the dietary habits of the patient he is not able to diagnose diseases and restore health for the patients" (*Susrut*, sutro sthan, chapter 46, paragraph 2). Susrut classified foods into various categories and described the quality, ingredients, organic and caloric components, metabolic functions, relations of particular foods with nature and the locations where they grow, functions in the body, times of intake, and the potential dangers of inappropriate intake (i.e., wrong times, seasons, proportion, etc.).

Rice is the first category, and is divided into various sub-categories depending on location of production (i.e. wet land, muddy land, dry land, etc.), as the quality of the rice and its function in the human body depends on the type of location in which it grows. There are eighteen types of instruction available in the *Susrut* concerning the best use of rice as food for human body and health. Green crops, lentils, red pulses, beans, enamel, vetches, gram, sesame, mole cowry, barley, etc., make up the next group of foods in the *Susrut Samhita* text. Assorted meats including beef, mutton, ram, deer, peacock, dove, lion, tiger, different sea animals, snakes, buffalo, duck, chicken, crocodile, and several fishes, including both sea fish and fresh water fish are in the third group of food. A variety of fruits constitute another group. Vegetables are in another category. Radishes, tubers and salted food are the next group. Desserts are the final group (*Susrut*, sutro sthan, chapter 46, paragraph 1-553)

Apart from foods and their ability to influence the human metabolic system Susrut also described the rules and regulations one needs to follow during regular dietary practice. Firstly, the kitchen should be wide, clean and purified, and surrounded with obedient people. Cooked foods should be preserved in a neat and clean area of the kitchen by honest and obedient persons (*Susrut*, sutro sthan). Susrut illustrated the procedure for serving preparations and noted that "a black iron pot should contain ghee/fat category of foodstuffs, meat should come in a silver pot, while straw and grains types of food should be preserved in stone pots. Eye-catching foods, cold water and milk-based food should be on copper plates, and drinks, including alcohol, should be stored in earthen or clay vessels. Fruits, *laddu*, etc., should be presented on the right side of the hungry person; while meats, drinks, milk, desserts (*peao*), custards on the left side" (*Susrut*, sutro sthan, chapter 46, paragraph

504). “The hungry person should eat an appetizer (*modhur*) first, the main course and salted foods (*onno and lobon*) in the middle and dessert (*ros*) at the end” (*Susrut*, sutro sthan, chapter 46, paragraph 507)

Susrut suggested the ideal conditions and surroundings for food intake: “Food should be consumed after sitting in a comfortable place, the body should be kept in a vertical position and unnecessary sluggishness or rush should be avoided during food intake” (*Susrut*, sutro sthan, chapter 46, paragraph 511). Susrut recommended the appropriate time of the day for eating in various seasons: “Those foods that function against disease should be taken in the morning if the night is longer than the day in a particular season, while food should be taken in the afternoon if day is longer than night in another season. Meals should be taken at least once between day and night if day and night are of equal duration - Autumn, Spring, etc.” (*Susrut*, sutro sthan, chapter 46, paragraph 511-513). Susrut recommended the avoidance of uncooked, unripe or spoiled (*bashi, pacha*) food, as well as insufficient or overintake; uncooked food increases disease which may even lead to death. “Spolied food causes loss of appetite. Overintake brings on lazy feelings, while inadequate diet causes loss of energy” (*Susrut*, sutro sthan, chapter 46, paragraph, 517). Enough rest after dietary intake and sitting like a king until tired casues one to leave is also suggested by Susrut. The text further denotes that “walking 100 steps afterwards and lying down on a bed on the left side is another positive indicator for effective digestion” (*Susrut*, sutro sthan, chapter 46, paragraph 527). The text also suggests smelling perfume or listening to music after dietary intake, which has a positive effect on digestion. However, the text also warned that “noisily laughing, smelling perfume or listen to

music during eating may cause vomiting” (*Susrut*, sutro sthan, chapter 46, paragraph 527).

Charok Samhita also puts special importance on food and beverage. The text mentions a conversation among sages about the origin of human diseases and its relation to individual dietary habits: “Kasipoti Bamok (a sage) asked Lord Atray about the causes of human growth and disease. Lord Atray replied that good beverages are the reason for human growth, while overintake of foods increases disease” (*Charok*, sutro sthan, chapter 24, paragraph 3).



P 2.3 - Lord Buddha



P 2.4 – Lord Siva

Source: P2.3 was published in the AYUSH Yearly Calender 2004 and P2.4 was taken by the author from a work published by Dabur India Limited.

Apart from textual references, the food and dietary practices of ayurveda are also verified by statements of practitioners today. Of those surveyed in Calcutta, 87% of the practitioners remarked that individual dietary habit has a significant impact on the body and health and suggest their patients follow dietary regulations, while 10% do not recommend any food restrictions. One physician’s description of the importance of food and dietary restraint as follows:

> "There are many foods used as home remedies in India - for instance, pomegranate (*dalim*), turnip, banana, carrot, sugarcane, potato, ginger, turmeric, cumin powder, etc. Some foods are use as vehicles for ayurvedic medicine - hot milk, honey, etc. It might be difficult for a physician to treat patients unless he/she can accurately determine *pattho* (food). In ayurveda, the physician has to follow different treatment procedures and instruct diversified culinary practices for different patients suffering from the same disease because of various ages, durations of disease, food habits, etc. The individual patient's pattern of disease and disease condition is another variable for food and dietary restriction. For instance, rheumatic arthritis is a common disease in Bengal which increases during the winter season because of low temperatures. Patients have to avoid cold food and follow other behavioural restrictions to keep the pain under control. Gas is another popular problem to visit ayurvedic practitioners which increases from shake-pata (green vegetables) and the physician has to restrict the patients to avoid green leaves and related foods. Any acidic sour foods, lemon, banana, pulse, lentils, etc., are also forbidden for a patient suffering from gas problem". (AP 3)

The importance of food and dietary practice in ayurveda has been recognized in both the textual ayurveda and empirically-gathered statements of modern practitioners. However, some of the food and dietary recommendations are contradicted by the requirements of various religions. For example, the *Susrut Samhita* describes good quality beef as included in medical recipes, but Hinduism forbids beef for its followers. Charok stated that "Beef is helpful to recover from dry cough and tiredness" (*Charok*, sutro sthan, chapter 24, paragraph 3). Likewise, Muslims avoid alcoholic substances, pork, etc. However, a significant number of patients from the Muslim community visit ayurvedic physicians for medical reasons. Many ayurvedic practitioners/*vaidyas* are culturally sensitive and would prescribe ayurvedic diets that are acceptable to their patients.

Ayurveda during the Buddhist legendary period

Apart from Hinduism's interfluence, ayurveda has also been subjected to Buddhist influence. While Buddhism did not develop its own medical systems, Buddhist monasteries began medical treatments of the lay community, generally using ayurvedic principles (Tucker, 2001:375). Many Buddhist scholars made positive contributions for the medicinal preparations and development of ayurveda. Nagarjuna, an alchemist, was one of the pioneers among them, having made remarkable contributions in the preparation of medicinal mineral substances (Ninivaggi, 2001:20). The Nagarjuna School developed various techniques to purify toxic substances, such as mercury, and render them non-toxic and suitable for human consumption (Ninivaggi, 2001:20). Buddhists scholars set up one of the most famous ancient Indian universities, 'Nalanda', which continued in prominence until the 12th century. Although the exact timeframe of the establishment of Nalanda University is debatable, it was between the third and seventh centuries A.D. Some scholars claimed that Nagarjuna was affiliated with that university during his experiments in ayurvedic mineral preparation.

Ayurveda in medieval India

The first Muslim ruler to lead a regular army into India was Muhammad-bin-Qasim, who was sent by Hazzaz-Bin-Yusuf from Iraq. Muhammad-bin-Qasim came by land along the Persian coast and defeated the local Indian king Raja Dahir in the year 711 A.D. The Arabs ruled over the part of India known as Sind for about 300 years without any further expansion. During the last quarter of the twelfth century India was again invaded, this time by Muhammad Ghur, who defeated the local Rajput King Prithvaraj in 1191 A.D. and captured Delhi. After a short period,

Muhammad Ghuri went back to Afghanistan and appointed Qutbuddin Aibak as his representative to rule India, and subsequently Qutbuddin conquered a large part of India (Jaggi, 1981:91-92). India was ruled by several other Muslim rulers afterwards: Shams-ul-din Iltutmish (1211-1237 A.D.), Sultana Raziyya, Ghiyasuddin Balban (1246-66 A.D.), Balban's son Muhammad (1266-1285 A.D.), Ala-ud-din Khiljis (1296-1321 A.D.), Muhammad bin Tughluq (1325-1352 A.D.), Muhammad Shah ii (1378-1397 A.D.), etc., and finally fell under the 'Sultan regime' until Jahir Uddin Babur founded the great Mughal Empire in 1526 A.D.

One of the noteworthy contributions made by Muslims in the medical field, under these Muslim rulers, was the introduction of the *unani* medical system, widely known as Persian-Arab medicine. The word unani is an Indian version of the name of Ionia, in Greece, where the unani system originated. The unani system was founded by Hippocrates (460-377 B.C.) and further developed by some famous Muslim scholars such as Galen, Ibi-Sina, etc. Unani medicine is based on the 'humoural' theory, according to which there are four humours (*akhlat*) in the human body: blood (*dam* or *khun*), phlegm *(balgham),* black bile (*al-mirra as-sawda*) and yellow bile (*al-mirra as-safra)* (Liebeskind, 1995). Each humour was qualified by its nature and elements, the natures being cold, dry, wet and hot and the elements being water, earth, air and fire (Liebeskind, 1995). According to Hippocratic thought, health depended on all the humours being in complete balance with each other. Any change in this balance brings about a change in the state of the body. The first traceable medical book on unani medicine written in India was a Persian translation of the *Kitab-ul-Saidana* (Materia Medica and Pharmacology) of Al-Beruni during the period of Iltutmish (Goggi, 1981:99). In the late sixteenth century, the city of Hyderabad was

planned by the Qutub Shahi Dynasty, and one of the first buildings founded was a hospital with a capacity for 4,000 in-patients (Goggi, 1981). *Hakim* is a title given to unani medical practitioners in India. There were two major categories of *hakim*. Some came from the Arabian Peninsula or Persia and were employed by an Indian government on a contract basis. A few of them returned to their home countries after their contract had expired, while others permanently settled down in India.

There were 45 eminent unani physicians patronized by the state at the time of Ala-ud-din Khalji (Goggi, 1981: 102). From the Sultane Regime to the great Mughal Empire, Muslim rulers patronised the unani medical system in India (Liebeskind, 1995). Gradually unani medicine became the main mode of treatment for the urban elite class because of this state patronage (Liebeskind, 1995). Liebeskind remarks that:

> "Rulers supported hospitals, medical libraries, schools and important hakims. The first centre of unani medicine in South Asia was set up in Lahore in the 1106s under the patronage of the son of the last Ghazni king. During the regime of Muhammad bin Taghluq (1325-52) there were around 70 hospitals in Delhi, while 1200 hakims found employment through the state" (Liebeskind, 1995:50).

Muslim rulers spent lavishly to build hospitals and provide medical services in urban areas. Under the Mughal Empire many hospitals, clinics and other medical infrastructure was established. Akbar the Great (1556-1605) was the pioneer among Mughal emperors in establishing hospitals in various locations of Delhi and Agra. During the latter part of the Mughal Dynasty, Aurangzeb (1658-1707) also built hospitals in the provinces, and in small towns. Sher Shah (1540-45) established health facilities along the Grand Trunk Road together with rest houses for travellers in an

effort to provide health care services for the people of the countryside. Sher Shah also attempted to employ at least one unani physician at all stations on the caravan routes and allocated state funds to support the *hakims* outside the important towns (Liebeskind, 1995:50).

There are several similarities between unani and ayurvedic medicine, especially in the fields of philosophy and diagnostic principle. Firstly, both ayurvedic *vaidyas* and unani *hakims* relied heavily on pulse checking as a method to identify diseases. According to the historian Barani, Ustad-ul-Atibba, a famous unani physician who occupied an esteemed position during the entire Alai period, could correctly diagnose a disease merely by feeling the pulse of the patients (Goggi, 1981: 102). Maulana Hamid Motraz was also famous during this time for his skill in diagnosing patients through pulse and urine checking (Goggi, 1981: 102).

Another similarity between ayurveda and unani medical systems was the grounding in humoral theory. Both systems recognized that bodily ‘humours’ could cause physiological disorder, and that the natural environment is a prime determinant of health. There are also similarities between ayurvedic and unani classical texts. *The Madan-ul-Shifa*, considered the classical unani text, contains a preface and discussion about the science of medicine and the fundamentals of medicine (Jaggi, 1981: 115). It has three chapters: the first deals with preliminary treatment, various stages of the treatment, impact of different seasons of the year, various kinds of surgical operation, etc.; the second chapter deals with conception and human anatomy; and the third with symptoms and treatment of different diseases (Jaggi, 1981: 115). The ayurvedic texts *Charok* and *Susrut Samhita* have similar, corresponding topics and classifications of

chapters. Apart from philosophical and textual similarities, both the ayurveda and unani systems heavily rely on plant, mineral and animal-based drug preparations.

It is contested indeed whether the introduction of unani medicine caused any decline of ayurveda. Critics have commented that unani medicine got patronage from the state and the royal court, and that this had a negative impact on the advancement of ayurvedic practitioners. Many ayurvedic practitioners were not employed in the imperial court, whereas unani practitioners were employed. However, another view regards the introduction of unani medical practices as positive for ayurveda, as both the systems benefited through mutual learning and sharing. Muslim scholars translated the anthologies of ayurvedic text into the Persian and Arabic languages, and adopted drugs and other therapies from ayurvedic practice from the thirteenth century on (Leslie, 1976:356). In the sixteenth century, Hakim Yoosufi, a physician at the courts of the Mughal emperors Babur and Humayun, synthesised "Arabian, Persian, and Ayurvedic thought, and produced a composite and integrated medical system" (Leslie, 1976:356). Leslie further states that:

> "Scholars like hakim Yoosufi probably had counterparts among ayurvedic physicians. Certainly Hindus became unani physicians without converting to Islam, and Muslims became ayurvedic physicians. Muslim rulers acted as patrons of famous ayurvedic scholars, and Hindu aristocrats sponsored *unani* physicians and the practitioners of the two systems seem to have collaborated, because each had much to learn from the other" (Leslie, 1976:356).

In modern India, a significant number of Muslim students are studying ayurveda. Of those surveyed, 10% of the undergraduate students at the J. B. Roy State Ayurvedic College and Hospital are Muslim. The religious representation of undergraduate and

post-graduate students and faculty members in two ayurvedic institutions in Calcutta are shown in the following table.

Table 2.2

Religious representation of students and faculty members in the J. B. Roy State Ayurvedic College and Hospital and the Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith

	Hindu	Muslim	Buddhist	Total
J. B. Roy State Ayurvedic College and Hospital (numbers of faculty member)	39	0	0	39
Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith (number of faculty members)	9	0	0	9
J. B. Roy State Ayurvedic College and Hospital (number of students)	231	27	1	259
Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith (number of students)	29	1	0	30

Source: Faculty members' attendance book at the J. B. Roy State Ayurvedic College and Hospital and Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith during my personal visit in August-September 2004. This faculty attendance book includes all *students* enrolled.

Conclusion

In the exploration of the development of ayurveda, this chapter has examined the importance of religious idealism influencing and shaping the medical system. The greatest influence comes from Hinduism, although Buddhism and Islam have also played a role. In addition, this chapter has examined the influence of the Hindu caste

system on the creation of a professional *vaidya* category of ayurvedic physicians. It has also provided explanations of the significance of plants and herbs in food and in the diets of ayurvedic patients. Finally, this chapter has attempted to determine how patients and practitioners view ayurveda as a medical system in modern India.

From Vedic origin through Hindu development, there have been mythological elements that have supported the relation between ayurveda and religion, Hinduism in particular. In the later part of its history, Buddhism and Islam also influenced ayurveda. Not only textual representations but also social institutions such as the Hindu caste system and food and dietary practices demonstrate that ayurveda contains religious elements, although there is still ongoing scholarly debate concerning their nature. However, empirical observation shows that patients and practitioners in modern Indian society distinguish ayurveda as a secular medical system. The religiosity of ayurveda has been replaced by a secular medical account given by modern ayurvedic practitioners and patients.

Chapter Three

Colonial and post-colonial state intervention

Introduction

For Benedict Anderson, "Western Europe in the eighteenth century marks not only the dawn of the age of nationalism but the dusk of religious modes of thought" (Anderson, 1983, 1991:11). Ernest Gellner believes that the secularism of modern European society only makes sense as a colonial theory (Gellner, 1983). In India, the age of nationalism emerged during the nineteenth century with European colonialism and many scholars believe that Western European modernization "would bring with it secularization in the world at large, religion does not seem to be giving way to more rational ways of explaining the world" (Hendry, 1999:128). As one of the world largest colonies in the nineteenth century, "Indian colonial rule was justified by the argument that the British were an enlightened and rational race of rulers who had to lead and develop the Indian people, steeped as they were in ancient prejudices" (Veer, 1998:483). This argument promoted a view that the British are able to take rational decision "in establishing a utilitarian state" in India because of their secular but Christian orientation (Veer, 1998:483). According to this view, both the predominant Hindu and minority Muslim communities in India were depicted as superstitious and sometimes religiously extremist. As indigenous medical practices, ayurveda and unani in particular, were inseparable from the Hindu and Muslim community in pre-colonial India they were thus stigmatised as a form of religious healing, along with magic, under British colonialism.

It was only after decolonization that indigenous medicines, in the post-colonial era, underwent revivalism in a nationalist response, especially after the formation of the Indian System of Medicine and Homoeopathy (ISM & H) in the 1970s. The broad objective of this chapter is to explore colonial subjugation and the nationalist revival of ayurveda. The chapter will explore the extent to which ayurvedic practices have been subjugated or replaced by the Western medical system in colonial India, and how the rise of nationalism during the colonial era led to a revival of ayurvedic practices.

Ayurveda under colonial subjugation

Much of India lost her independence in 1765 when the Nabab of Bengal was defeated by the British East India Company. Subsequently, the East India Company got the right to collect *deuani* (tax) from the Mughal emperor Shah Alam, which was the cornerstone of the British rule in Indian history. The Company continued its occupation and defeated different independent kings in several parts of India until the beginning of the nineteenth century. During the East India Company regime, different Europeans began to introduce Western allopathic medicine to the population. Jeffery points out that, many Company officials had consulted ayurvedic practitioners, in addition to European doctors, who also served as consultants to members of the Indian elite (Jeffery, 1988:50-51). During the British colonial rule, some Indians were given training in European medicine, as part of an expansion in medical services for the army (Jeffery, 1988:50-51). At the same time, the Court of Directors in London encouraged its employees to investigate the value of local Indian ayurvedic and unani medicines and medical texts (Jeffery, 1988:51). As continuation of such effort a scheme was approved to open a Native Medical School in 1822 in Calcutta, and 20

students were enrolled in this program (Jaggi, 1979:10). This school taught both indigenous and Western medicine. It was the first attempt to develop an integrated medical education in India. As ayurvedic texts were written in Sanskrit and unani texts in Urdu, Sanskrit medical classes were conducted at the Calcutta Sanskrit College and Urdu classes in the Calcutta Madrassa (Jaggi, 1979:10).

In 1833, Governor General Lord William Bentinck appointed a committee to inquire into the condition of medical training and the effectiveness of the functioning of the Native Medical School (Jaggi, 1979:10). The committee investigated and found the Native Medical School education defective, and recommended the immediate abolition of the Institution (Jaggi, 1979:10). The committee further suggested the formation of a Medical College for Indians in which the various branches of Western medical sciences already introduced in Europe should be taught in the English language (Jaggi, 1979:10). In accordance with the recommendations of the Medical Commission, Lord Bentinck, in January 1835, issued an order abolishing the Native Medical School (Kumar, 1998:23). That was the end of the first attempt at synthesis of Indian and Western systems of medicine in India. Calcutta Medical College was founded on 1st February 1835 to offer Western medical education, and several colleges and schools were opened by the second half of the nineteenth century for teaching Western allopathic medicine in the English language (Jaggi, 1979:11).

Dutta perceived that, under the British administration, the alien rules would be in accord with a 'treatment policy' where curing diseases, mostly epidemic and communicable, was the prime objective (Dutta, 2003:72). The British built up the health infrastructure, with hospitals mostly in cities or important towns for their own

people and for those natives who were serving them, in order to provide treatment (Dutta, 2003:72). As it was uneconomical to import medical professional trained in Western medicine from Europe to provide health care in India, the British administration set up a few institutions and training centres in the form of Western medical institutions for training nurses and other paramedical staff (Dutta, 2003:72). This step promoted the advance of allopathic medicine in India, as a result of direct colonial administrative support (Dutta, 2003:72).

As a result of this, there emerged a new class of urban elites among the native Indians with a Western outlook. They were trained in allopathic medical colleges founded by the colonial administration, and some of them were even exposed to British or European medical education. Jeffery further notes that, at the beginning of the twentieth century,

> "Medical bureaucrats became more self-confidently hostile to ayurvedic medicine. The Indian doctors with Western medical training were more conscious of its claims to scientific legitimacy. The number of Indian medical graduates and licence holders was substantial and they were offering a real challenge to the primacy of ayurvedic practitioners in the major towns, while the growth of a new Indian middle class provided new financial opportunities for both groups" (Jeffery 1979, 1988: 52).

At the dawn of the nineteenth century ayurvedic practitioner, kabiraj Raj Mohun Ray addressed a note to Sir Charles Elliott, Lieutenant Governor of Bengal, and urged for official encouragement and support for the establishment a college for ayurvedic teaching with a hospital attached to it but the request was turned down (Jaggi, 1979:12).

A second step was to promote Western allopathic medicine, with the adoption of new legislation and regulation, rather than to continue direct state patronage. In the 1910s, the Medical Registration Act was passed and enforced for compulsory registration of the practitioners of allopathic medicine, which disappointed the practitioners of indigenous medical systems (Jaggi, 1979:13). The positions of *vaidyas* and *hakims* were threatened by this law, which limited their right to become registered practitioner (Liebeskind, 1996). Also, the Medical Degree Act restricted the use of the title 'Doctor' to those trained in Western allopathic medicine (Liebeskind, 1996). Under these various acts, registered practitioners were forbidden to be associated with any indigenous system of medicine, or with their practitioners (Jaggi, 1979:13). This generated massive reaction among practitioners of the indigenous system of medicine such as native Indian doctors who were affiliated to teach in ayurvedic or unani colleges.

In the February 1918 session of the Bombay Medical Council, Surgeon General R. W. S. Lyons heard a petition from Sub-Assistant Surgeon Raghunath Vaman Bapat (Jaggi, 1979:13). The petition urged that Western medical doctors be legally allowed to teach the elementary principles of anatomy, physiology, medicine, etc., for the students at the Ayurvedic College in Kolhapur, in accordance with the Bombay Medical Act (Indian Medical Gazette, 1918:53,150; cited in Jaggi, 1979:13). The response of the Council and the resolution passed on the above stated petition was as follows:

> "Resolved that the Bombay Medical Council does not consider the association of a registered practitioner with any institution adopting any particular theory of medicine or surgery illegal, provided such association does not include any act which would render a registered medical

practitioner amenable to the discipline of the Council. In this connection, Mr. Bapat's attention is drawn to the appended 'Warning Notice'. " (Jaggi, 1979: 14)

The Medical Registration Act specified that "no certificate required by any Act from any medical officer shall be valid unless the person signing the same shall have been registered under the Medical Acts, and again no person shall hold any appointment as a physician, surgeon, or other medical officer in any dispensary, hospital, infirmary or lying-in hospital….as a health office….unless he be registered under the Medical Acts" (Jaggi, 1979:15). This Act favoured the doctors trained according to the Western medical system and discriminated against indigenous medical practitioners.

Kabiraj Gananath Sen stated, in a Memorandum on the Science and Art of Indian Medicine in the *Report of the Committee on Indigenous System of Medicine, Madras* 1923, that there were two factors that were causing a decline of ayurveda: firstly, the lack of recognition and support by the State and other natural patrons in the past such as princes, zamindars, local bodies, universities, etc.; and secondly, the establishment of the Western allopathic system of medicine as the official system, which was recognized and supported by the state (Jaggi, 1979: 16). Kabiraj Sen further said that:

"Is it any wonders that, under similar circumstances, the Indian systems have progressively suffered decay and that a sufficient number of the best brains of the nation are not attracted to it? Do we not see a similar feature in the field of literature pursuits also, where a good many of our best men prefer the study of English literature to that of Sanskrit or Arabic, because they find that the same amount of mental training or intellectual equipment in the former, which equates them to the professorship of English in the Indian educational service valued from

> eight to twenty hundred rupees a month, will not result, in case they pursue the study of Sanskrit or Arabic, in equating them to those exalted offices in the subordinate educational service held by our poor pundits and munshis passing rich on rupees forty to fifty a month. The case of Indian systems of medicine, is in one respect, even worse than that of the Indian literature; for the latter have at least some sort of official recognition though a very poor one, while in the case of former, they are either not recognized at all or recognized as 'quackery' " (Jaggi, 1979:17).

In later studies, many scholars also held similar views of the subjugation of indigenous medicine under the British colonial administration. Arnold perceived Western allopathic medical intervention in India as a 'colonizing process'. His argument is that "the history of colonial medicine serves to illustrate the more general nature of colonial power and knowledge and to illuminate its hegemonic as well as its coercive processes" (Arnold, 1993:8). Arnold raised concerns about the rapid progress of allopathic medical colonization in India. Arnold perceived the introduction of allopathic medicine as part of imperialism. The interests of different actors, including those of power politics, religion; and professional, class and economic interest; were involved therein. Thus, allopathic monopolization was part of colonial rule. Arnold concludes that "medicine cannot be regarded as merely a matter of scientific interest while it cannot meaningfully be abstracted from the broader character of the colonial order" (Arnold, 1993: 8).

Other scholars also agreed that the dominance of allopathic medicine in prestigious and well-paid areas of practice during the colonial rule was due to state patronage. As a result of colonial hegemony over medicine, Gupta argues that the

British policy favoured the flourishing of the allopathic system of medicine, and that this proved inimical to indigenous systems of medicine (Gupta, 1976:369).

As a result of various acts adopted by the colonial administration to protect Western medicine, in the first quarter of the twentieth century the Indian nationalist movement, with the support of indigenous medical practitioners, began an action to revive indigenous systems of medicine. In 1920 the Indian National Congress adopted a resolution that, as ayurvedic and unani systems of medicine in India were widely prevalent and generally accepted, there should be definite efforts by the people of the country to further popularise those systems through founding schools, colleges and hospitals (Jaggi, 1979:18). As a consequence of this resolution, various provincial governments formed committees to evaluate the situation of indigenous medical practices across the country. These were the Madras Committee 1921; the Bengal Committee 1921; the United Provinces Committee 1925; the Committee on Indigenous System of Medicine, Ceylon 1926; the Committee of Enquiry into the Indigenous Medicine, Burma 1928; the Indigenous Medicine Enquiry Committee, Punjab 1938; the Utkal Ayurvedic Committee, Orissa 1946; the Indian Systems of Medicine Enquiry Committee, Bombay 1947 (Jaggi, 1979:18-27).

The Bengal Committee 1921

The Bengal Committee was formed in August, 1921. There were three categories of members on the committee: ayurvedic practitioners, practitioners of allopathic medicine, and lay persons. There were differences of opinion from the beginning among the practitioners of ayurvedic medicine, those of allopathic medicine, and lay members of the committee, and each of the groups wrote separate notes (Jaggi, 1979:19). As there were controversial views among the committee

member, the committee was re-constituted and deliberated its report in 1925 (Jaggi, 1979:23). The observations of the committees were:

> "1. A very large section of the population of Bengal resort to ayurvedic medicine, either from preference or from necessity;
> 2. Household medicine, in Bengal, is based largely, if not entirely, on ayurvedic medicine;
> 3. Medical relief, as at present available, falls far short of the need of the population;
> 4. The extension of Western medicine on a scale large enough to meet the full requirements of the people does not appear to be practicable on financial and economic grounds;
> 5. Ayurvedic medicine is cheap, popular and efficacious;
> 6. Even in its present unorganised condition, it is resorted to by large masses of the population;
> 7. Organisation and restoration of this system of treatment to suit modern requirements is one of the best means by which we can hope to solve the problem of medical relief to the people" (Jaggi, 1979:23).

The committee further recommended that:

> "1. The restoration of ayurvedic medicine in its entirety and in its present condition without alterations and additions cannot be expected to lead to very successful results;
> 2. ayurveda should be restored for its utility and should therefore be developed with modifications and additions necessitated by modern advances and by the changes in the environment of the people who use it;
> 3. the main lines on which restoration and development can be undertaken are: a. the collection and organization of literature, b. the training of students and practitioners on proper lines; c. research should be conducted into the various branches of ayurveda, such as the pharmacological action of indigenous drugs, ayurvedic theories of pathology and therapeutics in their relation to treatment, etc." (Jaggi, 1979:23-24).

Although the Bengal Committee submitted its report to the government in 1925, no further action was taken for the next twelve years. On 2nd February 1937, the Local Self-Government Medical Department announced that "the Government found it impossible on financial grounds to undertake a scheme for the establishment of an Ayurvedic College and Hospital recommended in the report, but considered it desirable to establish a General Council and a State Faculty of Ayurvedic Medicine with the object of stimulating study of the ayurvedic system of medicine and of differentiating trained ayurvedic practitioners from untrained persons" (Jaggi, 1979:24). On the same day, "the Government promulgated statutes for the constitution of a General Council and State Faculty of Ayurvedic Medicine, on the clear understanding that no financial assistance will be expected from the Government for the maintenance of the Council and Faculty" (Jaggi, 1979:24). According to the Government notification, the main functions of the council were to hold examinations of candidates trained in recognized ayurvedic institutions and to regulate the standard of instruction in ayurvedic medicine (Jaggi, 1979:24). The council was to grant certificates or diplomas to successful candidates and maintain a register of qualified ayurvedic practitioners (Jaggi, 1979:24). This was a significant attempt, under the British colonial administration, to regulate and standardise ayurvedic medical education and practices.

However, the British divide and rule policy instilled a sense of communalism among native Indians and religion was used as a frontline tool to distance the Muslim and Hindu communities. This tension was also reflected among the indigenous ayurvedic and unani medical practitioners. The development of religious communalism during the beginning of the twentieth century, however, became rooted

in native Indian nationalist politics. The colonial power stimulated this tension in their own ruling interest, as anti-colonial sentiment was rising considerably and getting violent. As a result, indigenous practitioners of ayurveda and the unani system found it difficult to act together to counter allopathic medicine (Liebeskind, 1996).

Another attempt to revive and legitimize ayurveda was the introduction of integrated medical education, where students had to study both ayurveda and allopathic medicine for a medical degree program. The consequence of this was that "by the end of the nineteenth century ayurvedic practitioners widely recognized that in order to combat the increasingly widespread mimicry of European bodily practice it would be necessary to cope certain forms of European institutional practice" (Leslie, 1976, Langford, 2002:7). Other scholars, too, noted the professionalization of indigenous medicine in modern India, where ayurveda in particular followed the allopathic path as a result of the introduction of Western medicine during the colonial rule (Leslie, 1976). Leslie sees the emergence of medical syncretism, where both systems enriched each other through sharing and learning (Leslie, 1976). Bala argues that a professional model for both indigenous and allopathic medical professionals was in fact developed during the period from 1860-1920, noting that, although the colonial administration "were restrictive in their attitude towards indigenous medicine in government services, they were tolerant towards it in the delivery of medical services to the general population" (Bala, 1991:78). Various provincial governments, such as that of the Punjab, employed both *hakims* and *vaidyas* for providing medical services in different regions (Bala, 1991:19).

The debate on whether colonialism was an asset or liability towards the indigenous medical systems of India continues today. Professional ayurvedic groups are still divided over the impact of colonial rule on the indigenous medical systems. 40% of the ayurvedic practitioners surveyed in my research considered that British colonization had played a negative role on indigenous medical systems, as the health administration subjugated ayurveda and imposed allopathy; while 20% considered the British rule as having played a positive role for ayurveda.

There are various explanations given by present day practitioners concerning the negative impact of British colonization on ayurveda. Firstly, the British administration promoted the Western medical system. Indigenous practitioners felt discriminated against and undervalued because their skills were not regarded as of equal status to those of Western trained physicians with an MB degree. Furthermore, many of the ayurvedic physicians did not speak English, which had become the language of the elite. In this sense, they were seen as less modern than their English-speaking counterparts. Thirdly, the colonial administration which established ayurvedic colleges adopted an integrated education curriculum, combining ayurvedic and allopathic training, thereby diluting the ayurvedic contents. Finally, colonial rule promoted the use of the English language, resulting in decline in the use of Sanskrit, which was essential for ayurvedic texts that were written in Sanskrit.

Apart from its impact on the ayurvedic physicians' status in modern India, the colonially-supported allopathic system also impacted on Indians' ways of life. Western medicine relied heavily on chemical drugs produced by pharmaceutical factories, and on surgery. On the other hand, ayurvedic medicine and treatment relied

on plant and herb-based drug preparations and on the food and dietary practices. Introduction of modern medical equipment further caused a major setback to ayurvedic growth as, under colonial rule, there was also a dramatic change in people's dietary habits and lifestyles. The influence of the Vedas in Indian life was destroyed. Although the majority of Indians continued to live in rural villages, urbanization and migration to the cities had forced them to adopt a different lifestyle.

Other practitioners have noted that British rule brought about changes in the style of production and management of ayurvedic drugs. The British administration adopted modern science and technology in ayurvedic practice. However, many Indians, including members of the administration, became attracted to an ayurvedic treatment from the wider belief that it had no side effects. Generally, boys from Brahmin and/or *kabiraj* families continued the ayurvedic profession. These practitioners were trained through an apprenticeship system where knowledge was transmitted from their guru (teacher) to them. Their deep knowledge of the plants and herbs used for ayurvedic treatment enabled them to prescribe herbal medicine to treat disease and illness and to produce herbal-based drugs to sell. Still, the result of the introduction of the Western medical system and modern technology led to a decline in indigenous medical systems. Ayurvedic practitioners living in urban settings started to depend on commercially-manufactured drugs from large ayurvedic companies instead of preparing drugs at home based on their own knowledge. One practitioner commented that:

> "Every medical system has good and bad sides and no medical system is self-sufficient. Although the Muslim invaders introduced the unani system in India they never limited the use

of other systems such as ayurveda, yoga, siddha, etc. Allopathic medicine works quickly but both the ayurveda and unani medicine work slowly. Ayurvedic medicine does not work appropriately for acute diseases and allopathic system took this advantage as it functions promptly. Despite the fact that ayurvedic physicians are now in a better position than those of the British regime it is not yet comparable to the allopathic counterpart. The British rule and the introduction of the allopathic system suppressed ayurveda and the situation still remains. The numbers of allopathic and ayurvedic medical colleges, recruitment of physicians in government services show a clear discrimination. However, the overall health service delivery progressed rapidly under the British rule and the allopathic system was supportive here. The British administration also tried to bring ayurveda into the mainstream through adopting policy at different times, although the attempt was very slow because of overemphasis on allopathic medicine. There were two wings among the decision makers, the political wing and the administrative wing. In India the political wing worked for the development of ayurveda from the very beginning but the administrative wing did not cooperate. While the administrative wing dominated by the middle-class Western-educated group had no faith in ayurveda they did not trust ayurveda as a medical system. The political wing tried to develop ayurveda not only for political reasons but from their respect for ayurveda. The root of ayurveda was the common people although there are many myths about its origin. For instance, there are developed and developing countries, which is comparable with the top of the Himalaya Mountains and the bottom. Most of the people in ancient times lived at the bottom of the Himalaya, while very few were at the top. This is a metaphoric example comparable to the British rule in India. There were a few people fond of allopathic medicine and worked at the top of the British administration and allopathic medicine got the state patronage. On the other hand the mass of people were fond of traditional medicine which did not get too much state attention. Ayurveda has not been destroyed until now because grassroots peoples hold its base" (AK 7).

The subjugation of ayurveda to the Western medical system is further reflected in the comments of a patient:

"Ayurveda was 100% subjugated by the British colonial rule as they destroyed the plant-herb-based treatment and adopted modern technology-based treatment imported from the Western world. So far as I know, the ayurvedic system was developed over a hundred years by our *muni-rishis* and was more exposed to leaves or plants. During my childhood, once I cut a finger I used a leaf. Now if we cut, we use antiseptic and complete antibiotic course. However, this does not make any significant difference from a medical point of view. Although we used raw leaves from the plant it did not have side effects or harm. On the other hand, the introduction of the allopathic system rejected home remedial practice, which raised its un-hygienic nature, probable infection, etc. For example, many allopathic doctors warned me about the serious negative consequence of using antibiotics. There is a paradox here. On the one hand, they prescribed antibiotics for me, on the other hand warned me about the side effects. They write large volumes of medicine in the prescription unnecessarily. They get commissions or gifts from the pharmacy if they prescribe their medicine. The amount of commission is huge. I don't think that ayurvedic treatment is now in a better condition than (under) the British colonial rule. There is no infrastructure to continue a good learning and research system between the senior and junior doctors. In the allopathic medical colleges, I saw there were four or five junior doctors under a senior doctor. We need to make the radical change of infrastructure in order to make ayurvedic treatment sustainable. The government should allocate sufficient resources and monitor the proper utilization of the resources, while corruption in India has risen rapidly" (MP 3).

The role of the post-colonial state

After decolonization, India became independent and emerged as a nation state in 1947. Efforts were made to revive indigenous medicine such as ayurveda and unani with state backing. These included adopting policies and changing strategies to provide better health care services and integrating indigenous medicine into mainstream health. The following section will discuss how the Indian nation state deals with ayurvedic revival and how the practitioners and patients perceive these

state initiatives. In particular this section will examine the formation of various health committees, integration and mainstreaming of indigenous medical systems; and health policy and budgetary allocation in the attempt to revive these medical systems.

1. Formation of health committees

In post-colonial India, the health system inherited from the colonial structure and allopathic professionals remained dominant. Ayurveda and other forms of indigenous medicines continued to obtain minimum attention from the government. Under the Western medical system, there are 3 groups of players, namely: professional monopolisers, the corporate rationalisers, and the community (Allsop, 1995). The professional monopolisers are the Western medical doctors, who function as a dominant interest group and control the medical knowledge, explaining and reinforcing it. Political factions, other health professionals and administrators are the corporate rationalisers who work for the co-ordination and integration of delivery of health services (Allsop, 1995). In India, the professional monopolisers present in the state bureaucracy have been the key actors to patronise allopathic medicine. Practitioners of the allopathic system ensured majority representation on most of the health committees formed after independence.

After decolonization, several committees were formed by the Indian government to evaluate and revive indigenous medicines. One such early committee, under the chairmanship of Lt.-Col. R. N. Chorpa, was formed in 1946. The Chopra committee put more emphasis on various areas such as education, research, drugs standardisation, medical relief, etc. The report of the committee was published in 1948 and made the following recommendations regarding indigenous medicine:

1. "For rendering of medical relief, the Western and indigenous systems should be harmonised;
2. Synthesis of Indian and Western medicine is not only possible but practicable, though it will be time consuming and not easy. Immediate steps should be taken in this direction;
3. Curriculum should be so arranged as to give the student adequate knowledge of Indian medicine with essentials of Western medicine particularly in those branches where Indian medicine is deficient;
4. Curriculum should be uniform for the whole country;
5. Chairs of History of Indian Medicine should be established in modern medical colleges;
6. Teachers should be well paid;
7. There should be a National Medical Board consisting of two autonomous sections viz. Indian Medical Council and Council of Indian Medicine;
8. All teaching institutions should also be centres for carrying out research;
9. In the Research Institutes experts of both the systems should work side by side checking and verifying the various hypotheses and theories, either rejecting or harmonising them;
10. A central Research Institute should be established;
11. Proper identification of medical plants used in Indian medicines region-wise should be made;
12. A Materia-Medica for ayurveda should be compiled;
13. An ayurvedic pharmacopoeia by the Central Research Institute should be compiled;
14. Control should be exercised over collection and distribution of crude drugs"[12] (Ministry of Health Report, 1958:2-4).

To follow up some of the recommendations made by the Chopra committee and to take necessary action, another committee was formed under the chairmanship of Dr. C. G. Pundit. The committee's recommendations were contrary to many of those of the Chopra committee:

[12] Only the relevant part of the recommendation is quoted.

"1. That the incorporation of instructions in ayurveda, unani, etc., in the curriculum of modern medical colleges was not immediately feasible either at the undergraduate level or postgraduate level;

2. That teaching of modern medicine in Ayurvedic College was not advisable because of the low standards of the institutions and that the curriculum for integrated course proposed by the Chopra Committee will have to be revised only when the results of the work done at the Central Research Institute were available;

3. That there should not be a diploma and degree course in ayurveda because this will tend to continue the existing neglected state of affairs in ayurveda; and

4. That therefore there should only be one uniform course of training in ayurveda"[13] (Ministry of Health Report, 1958:6).

As a result of the Pundit Committee's Report, the Central Research Institute in Indigenous Systems of Medicine was created at Jamnagar in 1952 (Ministry of Health Report, 1958:6). As a continuation of all the efforts to revive indigenous systems of medicine, the Government of India appointed another committee in 1955 headed by Siri D.T. Dave. The Dave Committee basically considered the question of the regulation of the practice of indigenous systems of medicine and made the following recommendations:

1. "Institutionally qualified persons and traditional vaidyas and Hakims with fifteen years of practice should be on the respective State Registers;
2. There should be a Board in each State to control the practitioners of indigenous systems and also to regulate the academic teaching;
3. The privileges given to Registered practitioners of indigenous systems of medicine should be equal to those of the modern medical practitioners;

[13] Only the significant part of the committee recommendation has been cited here.

4. There should be one uniform standard of training, consisting of a course of five and half years including one year internship, with at least three months training in rural areas;
5. The basic qualification for admission should be intermediate in science with physics, chemistry and biology or Higher Secondary Examination, with basic knowledge of Sanskrit in both cases;
6. There should be a Council, on the analogy of the Indian Medical Council, to control teaching in all institutions;
7. The syllabus should be taken up by separate faculties of ayurveda affiliated to Universities" (Ministry of Health Report, 1958:6-7).

The Dave Committee also produced a model syllabus for the integrated course. Finally in 1972, the Government of India, by an Act of Parliament, established the Central Council of Indian Medicine (CCIM) for regulating education and registration in ayurveda, siddha and unani medicine. The government also established a research council, the Central Council for Research in Indian Medicine, Homoeopathy and Yoga (CCRIMH) in 1971 (Kurup, 2002). The state health ministry formed a directory of Indian Systems of Medicine and Homoeopathy (ISM&H) during the 1970s, which has recently been renamed the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH).

Jeffery perceives that in post-colonial India the context of health policy-making was shaped by the Health Survey, the report of the Development Committee, and the activities of the Central Council of Health (Jeffery, 1988: 112). In many areas the two reports overlap and show their common interest in rural health care, which was developed under the League of Nations Health Organization (Jeffery, 1988). Firstly, both the reports prioritized a socialized system of health services delivery where private medical practice was discouraged. The reports also emphasised that the health

sector should be treated as public service and controlled by the public sector instead of the private sector. Secondly, both reports gave importance to preventive measures rather than to curative ones in order to address health problems, and considered the people's nutrition status and general living standards as the major determinants of health. Thirdly, the integration of preventive and curative services was another priority of both the reports, and provoked the abolition of private practices by the doctors working in the government services. Fourthly, both the reports proposed village-level health centres for villages with a given population. And, finally, health education for the mass of the population, to change their habits, lifestyles and mindsets, and to engage the villagers in health service delivery, was also emphasised in both the reports (Jeffery, 1988:112-113).

There have been many criticisms of both the reports, which have been reflected in the Indian larger health practices. One main criticism is the role of the bureaucrats, whose presence often dictated policies in their implementation. Bureaucrats acted as members of a particular social class and/or organized pressure groups in the health sector of the newly independent India. Another criticism involves the interests of the allopathic medical practitioners, who were in a dominant position to provide professional health care and who ensured their economic interests by formulating health policy and system (Jeffery, 1988:167). The political process and sensitivity in the post-colonial state was another factor reflected in the health care service. In health policy formation there was a division of powers between the central government and the state government, and in the internal structure of the health ministries. The major portion of the national health budget was allocated to the allopathic system. Class interest among allopathic medical professionals was another issue because of the fact

that most of the students and physicians of the allopathic system came primarily from middle class backgrounds and were unable to relate to the common health problems of the mass of the Indian population (Jeffery, 1988:168).

Finally the recommendations of both the reports failed to popularise health care and its provision to the rural population with state backing. Health education and service were concentrated predominantly in the urban areas. The Ministry of Health, Government of India, had no ‘village level’ personnel until 1977 and the most vulnerable social groups living in the countryside remained largely excluded from health services (Jeffery, 1988:113). Although the Medical Education Conference of 1955 called for the establishment of rural field-practice for undergraduate students from the allopathic medical colleges, “it took the Medical Council of India nine years to respond by making three months of such experience mandatory” for undergraduate students as interns. However, one study conducted in 1974 founded that 60% of the forty-seven medical colleges surveyed replied that their rural internship program for undergraduates lasted less than two months, and for one-third of the medical colleges it was less than one month (Jeffery, 1988:258).

Primary health care centre in the post 1970s era

The situation began to change during the 1970s, when the Indian government adapted several policies to extend health services in the rural area and introduced several interventions to ensure health care reached the grassroots level. These attempts included the establishment of primary health centres, integration of indigenous medicine into the state health policy, community participation and involvement of village-level personal in health care services and establishment of

separate social and preventive medicine departments. In the year 1972 the National Service Act was adopted, which asked that qualified people, including doctors, under the age of thirty be liable to serve for at least four years wherever required by the state (Jeffery, 1988:259). The Medical Education Conference of 1955 also called for the establishment and strengthening of social and preventive medicine departments in order to raise the prestige of preventive medicine in health services delivery (Jeffery, 1988:256). This served as an important boost for social and preventive medicine in India, as it often tends to take a secondary position to general surgery or other forms of medical service (Jeffery, 1988:257).

Despite all these post-colonial efforts, practitioners of ayurveda, as well as patients, in contemporary India are careful to express their concern about the role of the post-colonial state to revive ayurveda. 60% of practitioners surveyed noted that the post-colonial government did not give much attention to the development of ayurveda in the immediate years after independence. Since the 1970s, the Indian state has attempted to revive ayurvedic medicine, with both the central and state governments taking positive initiatives in recent decades. Different offices and directories have been established, and redistribution and restructuring of the ayurvedic practitioners within the ministry have occurred. The central government has developed various research projects and tried to standardize the classical drugs. At the same time the government has consulted the public on the necessity of ayurveda. The Indian Medical Council Act was adopted and introduced ayurvedic medical education. However, ayurvedic medicine and practitioners have been confronted with the lack of uniformity and quality control in their treatments and in ayurvedic herbal medicine.

From our survey, 13% of the practitioners indicated that the Indian government had provided inadequate attention and resources for the growth of ayurveda. They argued that ayurveda and other forms of indigenous medicine should be provided with more funds from the national health budget, to provide more finance for ayurveda and to promote ayurveda. In addition, of patients who visited the public ayurvedic hospital surveyed, 42% stated that they did not know of government involvement in favouring ayurvedic treatments. Only 28% noted that the government had given attention recently to improvement of ayurvedic treatment. However, those who were still not optimistic about the role of the government for the growth of ayurveda marked several drawbacks, such as poor infrastructural facilities in the ayurvedic college and hospitals, especially those in West Bengal, where the mass of people were fascinated with the allopathic system and gave minimum social recognition to ayurvedic practitioners.

2. Integration of ayurveda and other systems of indigenous medicine into the mainstream health system

Integration of indigenous medical systems into the mainstream health system was one of the initiatives to revive and promote indigenous medicine during the post-colonial era. In India, there are two levels of integration in the health sector: integration of medical education and integration of health service delivery. Integration stemmed from a range of factors, including a shift among international donors and in national policy in favour of providing support for indigenous medicines and the high cost of allopathic medicine and its dependency on high technology. Over the last few decades, the official and commercial interest, and the value placed on, indigenous medicines and practitioners have grown considerable. It is also evident that, for the

majority of the world's population, indigenous medical care is the only accessible and readily available medical option (Hyma and Ramesh, 1994).

At present, the Primary Health Care model in India is one of the best examples of integrating indigenous medicine into mainstream health. Under this scheme the allopathic and indigenous practitioners of ayurveda and homoeopathy work under the same hospital structure in India. In West Bengal each primary health care centre has two allopathic practitioners, one homoeopath, and one ayurvedic practitioner. The impact of primary health care in rural Indian health care service is enormous because of the extension of health care facilities in rural areas.

However, there were different feelings among the ayurvedic physicians surveyed about the integration of different medical systems and health personnel in the health service. Most of them emphasized a parallel but not mixed health service delivery where a common infrastructure, hospital, health care centre, etc., could hold separate units run by the medical practitioners from various systems including allopathy, ayurveda, homoeopathy, etc. Many physicians were careful about integration for a variety of reasons. They emphasised the practical difficulties of integration because of diverse and different principles and modes of operation in different medical systems. However, there were some advantages to integration. Ayurvedic practitioners need to refer their patients to allopathic doctors in emergency cases, such as those requiring surgery, quickly. Another positive feature of integration noted by the physicians is the fact that various systems heal diseases differently, according to the diverse nature of the diseases. This provides patients with the option to choose a medical system they prefer, or which seems suitable for them. Physicians from various systems in India do acknowledge each other. The Primary Health Care

Centre (PHC) is an example where allopathic, ayurvedic and homoeopathic physicians work amicably under the same roof.

Yeta again, some practitioners were conscious of the possible risks and threats of integration, preferring to keep different systems separate to maintain their own group entities and specialties. And another difficulty of integration is methodological incompatibility. Different systems imply different methods during diagnosis, albeit with the common objective of curing the patients. The mode of actions involving drugs and the procedures to understand physiological facts in various systems are different. There is also the fear that given the popularity of the Western medical system, an integrated medical curriculum will lead to students' opportunity to study Western medicine to the detriment of ayurvedic medicine.

As it stands at the moment, the effects of medical integration are subject to various interpretations. For example integration may create an opportunity for practitioners to do cross practice. As allopathic medicine is more powerful for giving immediate relief, ayurvedic practitioners may be encouraged to practice allopathy, and ayurveda may eventually be destroyed, as students of ayurveda will be more eager to learn allopathic pharmacology and pathology. As integration is needed in particular circumstances, drug standardization, research on particular herbs and plants, identification of the potency of herbs, etc., will be carried out according to the need for modern instruments. One professor from the Ayurvedic College commented:

> "The meaning of integration can be interpreted differently, integration of education, integration of treatment, uniformity in education, etc.; and all these aspects are different. An ayurvedic physician's knowledge or expertise of modern basic science may not be as deep as

an allopathic physician. The World Health Organization (WHO) and other biggest organizations are thinking about the safety of patients more seriously than before because of the massive side effects brought on by the allopathic medicine. They are arguing about the possibility to develop patient-specific drugs instead of giving the same drug for all patients suffering from similar disease. This was the basic principle of ayurvedic treatment. Ayurvedic text described that the nature of every human being is different and it is essential to prepare patient-specific drugs. Ayurvedic physicians were following this principle from the very beginning. This is also one kind of integration I think.

Secondly, still we can not scientifically prove many aspects of ayurveda. Ayurveda is a knowledge-based medicine developed over the last 3000 years. As soon as we will be able to integrate the molecular-based science and knowledge in ayurveda, I believe we will find the scientific validity and potentiality of ayurveda. In order to ensure this, we need integration of knowledge and technology. However, if we consider integration as a channel to recognize the right of the allopathic practitioners to do practice in ayurveda and vies-versa, this integration is very contradictory" (AK7).

55% of the patients surveyed were optimistic about integration of different systems to ensure more efficient health service delivery. They supported the model of the Primary Health Care Centre. The advantages of integration and of bringing practitioners from different systems together in the same hospital are enormous. Integration can ensure accessibility and choice of different systems for the patients. Patients could decide their best options according to their needs, desires and disease patterns. Also, since practitioners from different systems have their own limitations, they could consult each other when they come to work within the same infrastructure.

3. Health policy and budgetary allocation for indigenous medicine

The Indian government adopted many initiatives through the national health policy, particularly in 1983 and 2002, to promote indigenous medicine. The national health policy in 1983 and the National Policy on Indian Systems of Medicine & Homoeopathy - 2002 emphasised the greater integration of Indian Systems of Medicine & Homoeopathy in the health care services. The 1983 National Health Policy was formally adopted by the Indian parliament in December of the same year. It recognized that the approach of indigenous medical systems in India was of a holistic nature, which took into account all aspects of human health and disease. The policy report further regarded that, because of various foreign influences over the centuries, different systems of medicine had evolved and were widely practiced in India. The practitioners of the various indigenous systems practiced in different parts of India enjoyed high local acceptance and respect from the community and hade greater influence in grassroots level health practices. It was, therefore, necessary to initiate a systematic and well-organized measure to regulate and systemize each of these indigenous medical practices, with state backing. These measures would also lead to a meaningful integration of those indigenous medical systems in mainstream health and use the services of the practitioners (National Health policy document, 1983).

The 2002 National Policy on Indian Systems of Medicine & Homoeopathy also emphasized the need for a meaningfully-based integration of Indian systems of medicine, with both ayurveda and allopathic medicine as the major foci. The policy noted some positive features of Indian systems of medicine, such as their diversity and flexibility, accessibility, affordability, broad acceptance by a section of the

general public, low level of technological input and growing economic value, etc. (National Policy on Indian Systems of Medicine & Homoeopathy, 2002).[14] The basic objectives of this Policy were:

1. "To promote good health and expand the outreach of health care to our people, particularly those not provided health cover, through preventive, promotive, mitigating and curative intervention through ISM&H;
2. To improve the quality of teachers and clinicians by revising curricula to contemporary relevance and researchers by creating model institutions and Centres of Excellence and extending assistance for creating infrastructural facilities;
3. To ensure affordable ISM&H services & drugs which are safe and efficacious;
4. To facilitate availability of raw drugs which are authentic and contain essential components as required under pharmacopoeia standards to help improve quality of drugs, for domestic consumption and export;
5. To integrate ISM&H in health care delivery system and National Programmes and ensure optimal use of the vast infrastructure of hospitals, dispensaries and physicians. Re-orient and prioritize research in ISM&H to gradually validate therapy and drugs to address in particular the chronic and new life style related emerging diseases;
6. To create awareness about the strengths of these systems in India and abroad and sensitize other stakeholders and providers of health;
7. To provide full opportunity for the growth and development of these systems and utilization of the potentiality, strength and revival of their glory" (National Policy on Indian Systems of Medicine & Homoeopathy, 2002).

The policy prioritised sectors with great potentials. Firstly**,** ISM&H physicians would be recruited for the primary health care centres. The Central Council for Health and Family Welfare in 1999 recommended that at least one physician from the Indian Systems of Medicine & Homoeopathy (ISM&H) should be available in every primary

[14] Soft copy of the National Policy on Indian Systems of Medicine & Homoeopathy 2002 was available in the CCIM web page.

health care centre and any further vacancies caused by non-availability of allopathic personnel should be filled by ISM&H physicians. The Council also proposed the introduction of specialist ISM&H treatment centres in rural hospitals in order to extend the benefit of these systems to the public in rural areas. Secondly, policy proposed increases of financial and budgetary allocation for the ISM&H and for medical education. The policy further noted a worry at the fact that ISM&H gets only 2% of the total health budget of the nation, while 98% is allocated for allopathic medicine, and suggested an increase in budgetary allocation up to 10% of the national health care budget within five years of the adoption of the policy (National Policy on Indian Systems of Medicine & Homoeopathy, 2002). The significant rise of national budget in recent years for the ISM&H is a positive indicator of the impact of this policy.

Table 3.1

National health budget in various five years plans and allocations for indigenous systems of medicine

Sector	First plan%	Second plan%	Third plan%	Fourth plan%	Fifth plan%	Sixth plan%	Seventh plan%
Health Control of communicable diseases	16.5	28.4	20.6	11.0	6.2	7.5	6.9
Medical education, research and training*	15.4	13.3 2.7	16.4	7.4 1.1	3.5 .6	8.3	7.3

Hospitals and dispensaries	17.9	16.0	18.1	14.3	16.3	10.3**	8.6**
Indigenous systems of medicine	.3	1.8	2.9	1.4	1.0		
Other programs	14.4	2.7	3.3	2.4	1.5		
Total Health	64.5	64.9	61.3	37.5	29.1	26.0	22.8
Family planning	.5	1.3	7.9	27.3	18.8	14.4	21.8
Nutrition	-	-	Na	Na	14.8	3.4	11.7
Water supply and sanitation	35.0	33.8	30.8	35.2	37.3	56.1	43.7
Total health related (INR, millions)	1,400	2,250	3,415	11,555	27,376	69,910	149,180

Source: Plan documents; cited in Jeffery, 1988:156-7

* Medical education is of doctors; Training is of paramedical workers.

**This figure is for "hospitals and dispensaries, medical education and research, traditional systems of medicine and homoeopathy, and others.

Table 3.2

Yearly allocations and utilization of funds for Indian System of Medicine & Homoeopathy (INR 10 million)

Year	Budget Estimates	Actual Expenditure
1997-98	35.30	33.04
1998-99	50.00	50.02
1999-20	59.13	49.05
2000-01	100.00	79.46
2001-02	120.00	82.15
2002-03	150.00	89.78
2003-04	150.00	133.96
2004-05	181.00	171.59
2005-06	345.00	

Source: AYUSH, 2003:225 and Ministry of Health and Family Welfare, Government of India webpage (http://mohfw.nic.in/reports/Performance%20Bud0506.pdf)

Table 3.3

Yearly estimated health budget and budget for the Department of AYUSH (INR)

Year	Estimated Health Budget (INR)	Estimated AYUSH/ISM & H Budget (INR)	% AYUSH/ISM&H get
1998-99	23,616,900,000	500,000,000	2.11% (App)[15]

[15] The % calculation is made by the author with using simple calculator

1999-20	24,491,700,000	591,300,000	2.41% (App)
2000-01	25,740,000,000	1,000,000,000	3.88% (App)
2001-02	27,471,200,000	1,200,000,000	4.36% (App)
2002-03	NA	1,500,000,000	NA
2003-04	29,219,500,000	1,500,000,000	5.13% (App)
2004-05	NA	1,810,000,000	NA
2005-06	NA	3,450,000,000	NA

Source: AYUSH, 2003:225 and Ministry of Health and Family Welfare, Government of India webpage (http://mohfw.nic.in/reports/Performance%20Bud0506.pdf)

Although the Indian government has promoted indigenous medicine, it is still the case that, in terms of budget percentages, the ISM&H got only 2% of the national health budget until the late 1990s. It was only in the early twenty-first century that the budget percentage for ISM&H increased - from 2.41% in 1999-2000 to 3.88% , 4.36% and 5.13% in the years 2000-01, 2001-02 and 2003-04, respectively. Although the budget percentage thus doubled over 3 years, it still only occupied 5% of the total health budget. However, the estimated budget doubled for 2005-06, jumping to INR 3,450,000,000 from INR 1,810,000,000 for the year 2004-05. All these are positive indicators for the attempt to revive Indian Systems of Medicine through state patronage.

The National Policy on Indian Systems of Medicine & Homoeopathy, 2002, also gave importance to drug standards, regulation and enforcement and prioritised the safety, efficacy and quality of drugs and their rational use. The policy recognized that there was reluctance among a large number of drug manufacturers to maintain a

standard quality control of their drugs because of the poor law enforcement mechanism. Medicinal plants and the ISM industry was another key area of policy emphasized, as Indian Systems of Medicine and Homoeopathy predominantly use plant materials in the preparation of their drugs. The policy indicated the availability of 8000 plants having medicinal properties, although only 500 of them are generally used. Most of these plants grow in the wild, as natural components of the vegetation of particular regions. However, this natural habitat and sources are declining due to over exploitation and population pressure.

The policy addressed the issue of intellectual property rights, as indigenous medical knowledge has drawn the attention of foreigners. The policy also highlighted the revitalization of local health traditions and encouraged medical tourism. Certain ayurvedic therapies, such as Panchkarma, massage therapies are becoming extremely popular among overseas health tourists and local Indian elites, and the policy prioritised and encouraged the further growth of these sectors (National Policy on Indian Systems of Medicine & Homoeopathy, 2002).

However, there are mixed feelings among practitioners about the current health policy and scope for them to work: 47% were optimistic about the current health policy, while 20% noted extremely limited avenues for them to get jobs in government services and 10% noted their limited scope to practice; while 7% emphasised that the policy created more opportunity for them. 7% noted that there is positive scope in some states of India such as Kerala, Gujarat, and others, but that the situation of ayurveda in West Bengal is extremely poor. The remaining 9% gave individual opinions about the scope of opportunity for ayurvedic practitioners.

The practitioners highlighted a variety of features of current health policy and opportunities for them to practice ayurvedic medicine. They can play a very positive role in building public awareness and increasing the popularity of ISM&H, as well as research collaboratively on herbal-based drugs, if the policy is implemented properly. The number of patients visiting ayurvedic practitioners has increased significantly. All these are positive factors for ayurvedic practitioners to work in both public and private sectors under current health policy and system.

Despite the state's promotion and attempts at mainstreaming ayurveda, however, there continues to be limited recruitment in the government hospitals and health care centres for ayurvedic physicians. Another obstacle faced by ayurvedic graduates is their inability to prescribe allopathic drugs because of certain Supreme Court injunction against the prescription of allopathic drugs by ayurvedic practitioners, as this places them in a marginal position compared to that of their allopathic counterparts.

In the 2002 National Policy on Indian Systems of Medicine & Homoeopathy, the government integrated ayurvedic health care services for patients. To ensure ayurvedic services reach the population, there is a need to develop an efficient and effective health service delivery network across the country. The ayurvedic practitioners and patients suggested various expectations concerning the ideal pattern of effective health service delivery. Health service delivery should be based on patients' needs and demands. There should be some private practice for ayurvedic practitioners, as well as public health centres for the poor community. Health service

delivery should target and reach the greater population. In West Bengal, the quality of health service in public hospitals is very poor. The private hospitals/health care centres charge high rates for treatment, and patients there get better service from the staffs; while staff are often overworked and underpaid in most of the public health sector and do not care much about the quality of service.

Conclusion

Any endeavour to write about and examine the indigenous medical practices in contemporary India is impossible without discussing the British colonial intervention. The coming of the British to India marked the entry of the Western medical system in the subcontinent and the beginning of the subjugation of existing indigenous medical systems. It has been claimed that the British medical policy in India was clearly subservient to the imperial rule. However, the post-colonial state has supported a revival of indigenous medicine in India. The professionalization of ayurveda in modern India, however, is under threat through a process of modernization in the hands of India's emerging elites. The revival of indigenous medicine, ayurveda in particular, in the post-colonial state has become an issue of professional and group interest. In modern India, the majority of ayurvedic practitioners perceive the role of British colonial rule negatively, despite the fact that they follow Western methods and frameworks to revive ayurveda.

Chapter Four

Ayurveda in modern Indian society

Introduction

In post-colonial Indian society, the Western medical system has become the key medical system catering to the masses. The government have endeavoured to provide this modern system to the masses at an affordable rate. However, when the Western medical system fails to provide definitive cures to long term and short term illnesses, some Indians, and especially those who can afford it, will explore alternative treatment methods. This chapter will explore and profile ayurveda as an alternative healing choice for a segment of the Indian population in Calcutta.

Calcutta was the capital of British India until the first decade of the twentieth century. It was symbolized as one of the prime locations of ‘European’ modernity in India during the colonial rule and was one of the pioneer cities in India in adopting Western science, technology and culture, and this is reflected in peoples’ lifestyles and behaviour today. The establishment of large number of allopathic medical colleges and hospitals in Calcutta during the colonial era to provide health care ensured the priority of Western medicine in the city.

Western medicine is still the mainstream healing choice for the majority of people, and the largest share of the West Bengal state government health budget is allocated for allopathic medicine. The budgetary allocation for the Indian systems of medicine, including ayurveda, is higher in the central government health budget than

in the West Bengal state government health budget, the estimated percentages in 2003-04 being 5.13% and 3.94% for the central government and the West Bengal state government, respectively.[16] Although in India there are 67.7 practitioners of ISM&H, including ayurveda, available for each million people, in West Bengal the number is only 56.4 (AYUSH, 2003)[17]. These figures indicate the lesser accessibility to practitioners of ayurveda and other systems of alternative medicine in West Bengal. In most cases, people consider ayurveda or other alternative systems of medicine only after the failure of Western allopathic medicine.

Table 4.1

Actual expenditure on medical services in West-Bengal (Health Budget)

	2000-01 (%)	2001-02 (%)	2002-2003 (INR in thousands)	2002-2003 (%)
1. Medical				
Urban Health Services – Allopathic				
a) Direction and Administration	4.92	4.67	425,825	4.09
b) E.S.I. Schemes	6.22	6.60	667,497	6.41
c) Medical Stores Depot	4.53	3.05	480,959	4.62
d) Hospitals and Dispensaries	50.70	53.59	5,286,812	50.78
e) School Health Scheme and Other	.04	.01	1,174	.01
Total	66.41	67.92	6,862,267	65.91

[16] For the figure on national statistics, please visit Ministry of Health and Family Welfare web page, Government of India. For the figure on West Bengal State statistics, please see Health on the March West Bengal 2003-04: 64, Directorate of Health Service, Government of West Bengal.

[17] For the State-wise availability of AYUSH doctors for population (institutionally qualified + non-institutionally qualified registered practitioners) please see appendix 2

Urban Health Services - Other systems of medicine				
a) Ayurveda	0.62	0.65	73,660	0.71
b) Homoeopathy	0.66	0.74	93,671	0.90
c) Unani	0.03	0.01	1,821	0.02
Total	1.31	1.40	169,152	1.63
Rural Health Services – Allopathic				
a) Primary Health Centres	13.50	14.84	1,576,842	15.15
b) Hospitals and Dispensaries	2.02	1.64	180,516	1.73
c) Other Expenditures & Special Component plan for SC	4.58	1.65	292,557	2.81
Total	20.10	18.13	2,049,915	19.69
Rural Health Services - Other systems of medicine				
a) Ayurveda	0.87	0.97	102,303	0.98
b) Homoeopathy	1.26	1.32	134,990	1.30
c) Unani			288	
d) Special Component plan for SC			3,460	0.03
Total	2.13	2.29	241,041	2.31
Medical Education - Training and Research				
a) Allopathic	10.06	10.26	1,082,291	10.40
b) Other systems	0.00	0.00	0	0.00
c) Special component plan for SC	0.00	0.00	6,652	0.06
Total	10.06	10.26	1,088,943	10.46
Total Medical Budget	100.00	100.00	10,411,318	100.00

Source: Health on the March West Bengal 2003-04: 64, Directorate of Health Service, Government of West Bengal

However, there has been a rising trend for health care facilities for ayurvedic treatment in recent decades in India, although it is not yet risen to the level of that for its mainstream allopathic counterpart.

Ayurvedic health service facilities in modern India

According to AYUSH in India for 2003, there are a total number of 2,253 ayurvedic hospitals available in India, with a total of 43,803 beds (AYUSH, 2003:48-49). Out of these, there are 4 ayurvedic hospitals with a total of 409 beds available in West Bengal (AYUSH, 2003:48-49)[18]. Apart from these hospitals, there are 13,925 ayurvedic dispensaries available in India, and 295 of these are located in West Bengal (AYUSH, 2003: 50). Although this figure is much lower than that for allopathic hospitals, there has been a significant rise in the establishment of ayurvedic hospitals during the last two decades. In 1980 there were a total of 252 ayurvedic hospitals available in India, but this figure had risen to 2,253 in 2003 an increase of nearly ten times within two decades. There were a total number of 11,631 dispensaries that provided ayurvedic health care available in India in 1980, but this number rose to only 13,925 in 2003 (AYUSH, 2003:51)[19]. The table below shows the establishment of ayurvedic hospitals and dispensaries in India from 1980 to 2003.

[18] For the list of State-wise numbers of AYUSH doctors (Institutionally qualified + Non-institutionally qualified registered practitioners), hospitals, hospital beds and dispensaries please see appendix 3
[19] For the summary of infrastructural facilities for ayurveda under AYUSH please see appendix 4

Table 4.2

Yearly progress of the number of ayurvedic hospitals and dispensaries in India (1980-April 2003)

Year	Hospitals				Dispensaries			
	Govt.	Local Body	Others	Total	Govt.	Local Body	Others	Total
1980	219	Nil	33	252	7,407	4,224	NA	11,631
1981	243	NA	33	276	7,821	4,233	64	12,118
1982	258	2	48	308	8,362	2,657	1,175	12,194
1983	284	4	43	331	8,508	2,081	1,857	12,446
1984	1,333	79	40	1,452	7,293	3,099	708	11,100
1985	1,341	77	42	1,460	8,289	3,101	721	12,111
1986	1,350	77	42	1,469	8,329	3,109	671	12,109
1987	1,365	79	42	1,486	8,700	2,235	1,419	12,354
1988	1,378	77	46	1,501	9,165	1,953	1,394	12,512
1989	1,382	77	68	1,527	9,792	1,673	1,374	12,839
1990	1,383	77	70	1,530	9,959	1,664	1,357	12,980
1991	1,917	77	62	2,056	10,213	1,617	1,353	13,183
1992	1,926	77	65	2,068	10,344	1,622	1,359	13,325
1993	1,961	77	73	2,111	10,611	1,622	1,382	13,615
1994	1,966	77	93	2,136	10,664	1,598	1,381	13,643
1995	1,969	78	94	2,141	10,834	1,569	1,296	13,699
1996	1,969	78	94	2,141	10,834	1,569	1,328	13,731
1997	1,977	82	120	2,179	10,994	1,808	1,192	13,994
1998	1,986	82	121	2,189	11,252	1,808	1,192	14,252

1999	1,984	113	120	2,217	11,846	1,339	1,231	14,416
2000	2,762	33	136	2,931	12,161	1,442	1,190	14,793
2001	2,773	33	149	2,955	12,305	1,423	993	14,721
2002	2,752	34	146	2,932	12,085	1,468	972	14,525
2003	2,061	34	158	2,253	12,779	1,119	27	13,925

Source: AYUSH, 2003:51

Ayurveda for common diseases

The ayurvedic system functions parallel to the allopathic system, and many common and serious diseases and other illnesses can be treated by this alternative system. Thus, for many of the patients who explored ayurvedic treatment did so as the result either of personal reference or because allopathic treatment had failed to cure them. One of the most common diseases leading patients to visit ayurvedic practitioners is arthritis. Out of the 75 patients interviewed, 41 were female and 16 were suffering from various types of arthritis, including thyroid arthritis, rheumatic arthritis and coronary arthritis. All the 16 arthritis female patients were housewives. The ayurvedic physicians mentioned that the prevalence of arthritis in women is culturally determined, due firstly to the nature of women's involvement in the domestic spheres, and secondly to their lack of mobility. Housewives in Bengal are predominantly occupied with domestic duties, including cooking and washing. They use a special type of chopping knife, a *boti,* which they have to use with a particular motion while they sit and chop vegetables, etc. This has a severe impact on the blood circulatory system in the lower part of the body, and arthritis symptoms gradually develop. Housewives in Calcutta are generally less mobile than men and do not do physical exercises. Such a lifestyle can contribute to the development of arthritis.

Table 4.3

Common disease patterns leading to the choice of ayurveda in Calcutta

Disease pattern	Number of patients	%
Arthritis: Thyroid Arthritis, Osteo-Arthritis, Rheumatic Arthritis, Coronary Arthritis	16	21%
Gastric Problems and Ulcers, Irritable Bowls Syndrome	7	9%
Body Pain (problem of bile), Shoulder Pain	6	8%
Common Illness: Fever, Cold, Cough, Running Nose	6	8%
Stomach Problem, Acidity and Indigestion	5	7%
Constipation and Gas	5	7%
Blood Pressure, Hypertension, Blood Sugar	4	5%
Bronchial Asthma,	3	4%
Skin Disease and infection	3	4%
Liver Problem, Kidney Problem, Jaundice	3	4%
Migraine, and Uteral Problem	2	3%
Dust and Food Allergies	2	3%
Heart Disease	2	2%
Paralysis	2	3%
Piles and Fistula	2	2%
Others (Premature Sex, Dysentery, Infertility, Hernia, Obesity, Headache, Voice problem)	7	10%
Total	75	100%

Likewise, the survey data from the Central Research Institute (Ayurveda) also confirmed that arthritis was one of the leading diseases in both its in-patient and out-

patient departments. In the year 2002-2003, there were a total of 491 male and 673 female new patients admitted to the in-patient department. Out of these, 30% of males and 71% of females were suffering from various forms of arthritis. In the same department, there were 482 male and 655 female old[20] patients admitted, with the arthritis cases also respectively 30% male and 71% female. The percentage of arthritis cases among females was thus much higher than for males, and occurred primarily among older patients. In 2003-04, the out-patient department registered a total of 4,515 male and 3,424 female new patients, and the numbers of arthritis cases were respectively 15% male and 26% female. The numbers of old male and female patients visiting out-patient departments were respectively 9,398 and 7,816. The relative numbers among old patients are reversed here while the percentages of arthritis cases were 14% male and 24% female[21].

Beside arthritis, ayurvedic clinics also treated other types of diseases in the out-patient department, including peptic ulcer syndromes, piles, fistula, hepatobiliary disease, limboceatica syndrome, heart disease, conghing, joint pain, constipation, painful urine, loose motion, diabetic mellitus, asthma, headache, lenkoderma, skin disease, abdomenal pain, eczema, duodenal ulcer, dysfunctional uterine bleeding, menstrual disorder, peptic ulcer, paralysis, respiratory infection and rheumatism (Central Research Institute, Annul Progress Report 2003-04:70-73).

[20] 'Old patients' means patients with existing diseases or illnesses who made repeat visits.

[21] For the statement of patients attended at OPD during 2003-04 in the CRI please see appendix 5

Table 4.4

Patients attending OPD for top 25 diseases during the reporting period 1st April to 31st March 2003-04[22] in the Central Research Institute (Ayurveda) Calcutta

Disease	Those who had newly acquired the disease		Those with existing illness	
	Total male (Adult + child)	Total female (Adult + child)	Total male (Adult + child)	Total female (Adult + child)
Piles	153	65	465	178
Peptic ulcer syndromes	844	574	2246	1563
Arthritis and rheumatism	674	898	1327	1890
Fistula	43	14	150	31
Hepatobiliary disease	81	36	310	99
Lumboceatica syndrome	50	44	108	137
Heart disease	28	18	76	47
Fever (general)	41	47	52	72
Conghing	180	65	366	209
Worm infection	78	44	170	107
Joint pain (*Katisula*)	66	47	174	131
Constipation	194	107	469	280

[22] Only common diseases are cited here.

Painful urination (*Mutra Kriccra*)	68	22	166	69
Dysfunctional uterine bleeding	5	146	18	381
Loose motion	213	83	630	247
Diabetic mellitus	289	156	289	156
Menstrual disorder	-	111	-	148
Asthma	147	55	289	110
Headache	47	51	61	87
Lenkoderma	52	52	151	205
Skin disease	137	101	171	159
Abdomenal pain	188	150	185	287
Eczema	72	25	130	54
Duodenal Ulcer	49	20	105	43
Total	4515	3424	9398	7816

Source: Central Research Institute (Ayurveda), Annul Progress Report 2003-04:70-73

One patient recalled her encounter with ayurveda:

"I had serious pain in the joints of my legs, hands and arms. I couldn't carry or move any heavy goods or things. I found it difficult to move my hand sometimes. It first started from the knee joint. I discovered that the pain comes in the morning. I visited Thakuria Arobindo Shaba Shadon for allopathic treatment. They made pathological diagnosis including a blood test and gave some medicines. I took 18 days of physiotherapy. Every day I had to pay INR 45 for physiotherapy. The pain in the lower part of my leg decreased. However, the upper position in my knee joint was swollen. I stopped taking the treatment as I was more or less stable in the

> meantime. The same pain came back to my hand after 8-7 months. The feeling of the pain was not quite similar but once I move the hand I felt discomfort. My house is located in Canim near to the Sunderban area. There was a patient from my area who took the medication from this ayurvedic research hospital. He shared his experience with me and suggested I visit here as he got benefit after taking medicine from here. Finally I reached here. I have come here for the last three weeks. Today I came to do a pathological test for my blood. I feel slightly better now. The doctor suggested I make oil massage on my foot with garlic salt and *Nishinti pater Rosh* (special kind of herbal leaf). I made that oil and used it on my hand and leg. The doctor asked me to buy some medicine from outside and I bought it. The doctor recommended an ayurvedic shop in the market where the medicine is available (FP7).

Priority of medical system

From the survey conducted, it was found that 58% of the patients had visited an ayurvedic physician for treatments of ailments that they had had ranging from 2 to 10 years. The majority of the patients sought ayurvedic treatment when they found Western allopathic treatment had become ineffective. Unlike, allopathic treatment, which involves the prescription of powerful drugs that give immediate relief, ayurvedic treatment aims for long term cures, with no immediate relief from the symptoms of the illness. Sometimes patients also use homoeopathy in addition to ayurvedic treatment. The table below shows the survey findings, according to which an overwhelming 81% continued to consult allopathic physicians in the first instance. Ayurveda only becomes an alternative choice when allopathy failed.

Table 4.5

Comparative table of the priority of choice of various medical systems by patients

Choice	Allopathy	Homeopathy	Ayurveda	Unani
1^{st}	61 (81%)	9 (12%)	5 (7%)	0
2^{nd}	8 (11%)	36 (48%)	19 (25%)	0
3^{rd}	0	0	50 (67%)	1
4^{th}	0	0	1	0
Didn’t choose	6 (8%)	30 (40%)	0	74
Total	75	75	75	75

From the survey it was found that the fee for a private ayurvedic physician ranged from INR 100-150 per visit for both consultation and ayurvedic medication. This is relatively high in comparison to outpatient charges in government public clinics or hospitals, which charge a flat fee of INR 19, including one week’s supply of medicine. From the survey, it was also found that those patients who consulted private ayurvedic physicians tended to hold highly-skilled professional jobs with monthly incomes of INR 10,000-40,000[23] and are middle class. Very few working class Indians with monthly incomes of INR 1000-5000 could afford to pay for a consultation with a private ayurvedic physician. Working class Indians primarily relied on the ayurvedic treatments provided by government out-patient clinics or hospitals.

[23] 90% of the surveyed patients who visited private ayurvedic practitioners belong to the INR 10000-40000 income group and 70% of the surveyed patients visiting public clinics belong to the INR 1000-5000 income group.

Among the ayurvedic undergraduate students surveyed, 95% listed their first choice of study was to gain admission to an allopathic medical college to study for MBBS or BDS degrees. The first choice of all of them was to study allopathic medicine. When they failed in gain entry for allopathic medical study, they chose ayurveda as their second option. These undergraduates had also repeatedly tried to enrol in the allopathic medical colleges without success. 45% of the surveyed students had sat for joint entrance exams two times, 40% three times and 10% one time, to get admission to an allopathic medical college.

In West Bengal there are two different joint entrance examinations to study medicine – the joint entrance examination for studying for an MBBS (Bachelor of Medicine and Bachelor of Surgery) and/or BDS (Bachelor of Dental Surgery) at an allopathic medical college, and the joint entrance examination for studying ayurveda, homoeopathy and physiotherapy courses. The joint entrance examination to enrol in allopathic medical colleges is given at an earlier date than that for ayurveda and other systems.

There are several reasons for the students' priority choice of allopathic medicine. One is that being a qualified allopathic doctor confirms higher status. In addition there is a greater availability of jobs for allopathically-trained doctors.

Only the *kabirajes* who had come into the profession through the apprenticeship system did not consider the allopathic system as their first priority. With the professionalization and the awarding of formal degrees to ayurvedic

physicians, it is not surprising that only 20% of them had successor coming in ayurvedic profession through the apprenticeship system. As one *kabiraj* commented:



P 4.1-4.2 (An ayurvedic *kabiraj* employs the pulse checking method to diagnose disease)

Source: Photos were taken by the author during participant observation

> "I chose ayurveda because it has been our family profession for the last four generations - from my great-grandfather, grandfather, father and me. My grandfather was a famous and renounced ayurvedic *kabiraj* who established an ayurvedic college in Calcutta in his name, Shamadas Baspoti. Unfortunately there is no other person from my family coming into this profession after me. That is the tragedy and I really feel sad for this. My only daughter is a professor of Bengali literature. My great-grandfather was *kabiraj* Annodaproshad Gupto, who practiced *kabiraji* free of charge. My grandfather, *kabiraj* Shamadas Baspoti, was a reknowned physician who did the treatment of Sarada Moy, wife of Ram Krisno Deb. My father, *kabiraj* Bomolanando Tarko Tirtho, did the treatment of Rabindranath Tagore and many other famous persons in India and was involved in politics and was a follower of Nataji Subhash Chandra Bose and became uncontested minister from Rajshahi. He was also the secretary of the Parliamentary Group of the Congress Party. I really feel very disappointed to see that I don't have a next generation in ayurveda. If we write our knowledge on ayurveda in a book, there is nobody to read it. If you do practice, it is very difficult to write since (you) are always busy with patients. It is indeed sad that our knowledge will be lost after we pass away. But if you see this from another outlook, it is also true that a Rabindronath is born and you

> can't make them through training or education. Similarly good physicians are also born and it is not possible to make them through proper training. It needs concentration and passion. Today's physicians are all mechanical, depend on clinical diagnosis. They even don't understand the pulse. One can't gain the knowledge, experience and understanding of pulse checking from reading book, but need extreme concentration" (AK6).

Informal practice

Apart from the formal sector of ayurvedic practice in modern India, there is an informal sector. Various forms of indigenous medicine and healing practice are common features in various settings of India, and this represents a true medical pluralism. There are medical practitioners using a variety of herbs and plants to treat patients. Some of them claim to be ayurvedic *kabirajes*, although there is no official recognition for them due to their lack of formal training. Such practices are often considered illegal and are strictly prohibited by the state. However, they exist because of the fascination of the patients. Leslie mentions a total of 9 forms of medical practice existing in Indian society. These are; 1) the ayurvedic medical practice based on classical Sanskrit texts; 2) unani medical practice based on classical Arabic texts; 3) the syncretized medicine of traditional culture of learned practitioners; 4) professionalized ayurvedic and unani medicine, 5) cosmopolitan medicine or allopathic medicine, 6) folk medicine of various kinds, such as the practices of midwives, bone-setters, supernatural curers of various types, etc.; 7) popular cultural medicine which has emerged with the "institutions and enthusiasm of the mass society"; 8) homoeopathic, siddha, naturopathy, etc. - special forms of popular-culture medicine; and 9) learned magico-religious curing which is accepted by various classes of people in India, for which the "practitioners range from illiterate villagers" to educated urban folk (Leslie, 1976:358-360).

Taylor found that the formal Indian heath sector, or the organized health services, provides only 10% of the country's total medical care, with another 10% provided by the trained practitioners of various systems and operated by the private sector, especially in the cities or towns (Taylor, 1976: 286). The other 80% of Indian health care is provided by home medical carers and indigenous medical practitioners (Taylor, 1976:286). From Taylor's survey, conducted in 1965 in Punjab, it was found that 36% of the apprentice indigenous practitioners received apprenticeship training in ayurveda, 15% in unani, 3% in homoeopathy, 15% in Western allopathic medicine, 22% in a combination of Western and one or more indigenous schools; while 7% of such practitioners had had no apprenticeship, and concerning the remaining 2% Taylor had no information (Taylor, 1976:286). The scenario has not changed that much in contemporary Indian society. It is not unusual to find an indigenous healer selling his remedy on the street of Calcutta, although with fear in his eye that a policeman might catch him. Also, the urban and educated middle class rush to saints (*pir* or *fakir*) or magico-religious healers for remedies after the failure of conventional medical systems. Of those patients surveyed in the city of Calcutta, 65% had not had any experience of visiting a quack practitioner or healer from the informal sector. However, this might not be the situation in rural settings where access to institutionally-trained practitioners is limited.

Problems facing ayurveda

Although ayurveda is gradually gaining in popularity, it is still a long way from becoming an alternative medical system for the Indian masses. There are several reasons that served to hinder its acceptance by the masses. First, there is its elitist image and its relatively high consultation fees, as opposed to the low subsidized fees

of government allopathic clinics and hospitals. This reinforces the perception that ayurveda caters only to the middle classes. Another obstacle faced is that of the qualifications, skills and quality of the ayurvedic physicians. Given the fact that there are ayurvedic physicians trained through the traditional apprenticeship system as well as those trained in modern universities, it becomes important to establish a yardstick to measure them. At the moment, there is no clear yardstick with which to measure, especially for those trained in the traditional apprenticeship system. This problem is further compounded by the presence of 'quack ayurvedic physicians'. However, these too continue to play an important role by providing basic health care services to the rural population. They are found in many rural settings in the developing world.

Another problem faced by ayurvedic physicians is the generally lower status accorded to them in comparison with that of the physicians trained in Western medicine. One practitioner stated:

> "Although the government has decided to ensure equal status, the professional satisfaction is different. It comes from two ways: firstly, the patients love, and secondly, the recognition from the society. In this context, if I compare an MBBS and a BAMS doctor, I don't think that both are equal. Now the government has employed ayurvedic physicians in the government hospitals, founded ayurvedic dispensaries all over the country. I find that both the Indian central government and the West Bengal government are eager to promote ayurveda. But patients still lack faith in us. A patient will visit allopathic hospitals first when he/she falls ill" (AP3).

Another cause for the lack of ayurveda's popularity among the masses in Calcutta is the minimum campaigning as medical issue. Media advertisements are dominated by health products manufactured by the biggest pharmaceutical companies.

Pharmaceutical companies used the label ayurveda but they are reluctant to promote ayurveda as a medical system among the Indian masses. Of those surveyed, only 4% of patients had been informed about ayurvedic health care facilities from the media. Some of the middle class professionals had visited such facilities as the Vedic Village Spa because of the influence of the media. 68% of the surveyed patients had been informed about ayurvedic practitioners by neighbours, other family members, relatives or friends.

Conclusion

Neither patients nor young practitioners in Calcutta chose ayurveda as their first preference. Only the *kabirajes* from the apprenticeship system preferred this profession and did not prioritize Western medicine. A clear hierarchy of preference existed, with allopathy at the top. However, consciousness among patients has increased in recent decades of the severe side effects of allopathic medicine, and some had started to look for possible alternatives. In most cases they had switched over to homoeopathy and/or ayurveda. Disease patterns were another popular reason for moving towards ayurveda. Awareness has grown about the permanent curability from chronic diseases by ayurvedic treatment, and this has increased the demand. However, inaccessibility of quality drugs and herbs and reliable practitioners were major setbacks of patients trying to satisfy their needs.

Young ayurvedic students choose to practice ayurveda because of their failure to gain admission to Western medical colleges. However, the professionalization of the awarding of the formal BAMS (Bachelor of Ayurvedic Medicine and Surgery)

degree by the Indian ayurvedic colleges has encouraged many students to study and train in this profession.

Chapter Five

Professionalization of ayurvedic education in modern India

Introduction

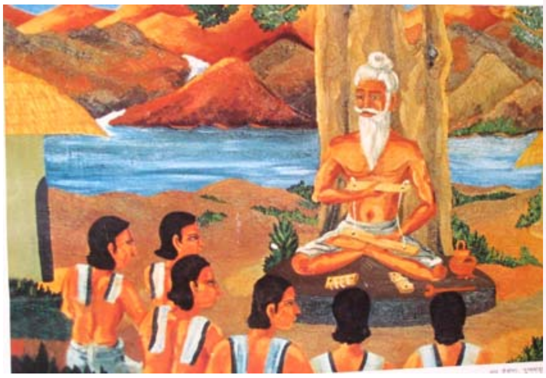
Many scholars argue that contemporary professional ayurveda, ayurvedic education and training in particular, were founded during the British colonial rule and followed Western lines (Leslie, 1976; Hollen, 2005). However, it could be contended that extraordinarily professionalized ayurveda was practiced during ancient and medieval India and that ayurvedic scholars were affiliated with ancient Indian Universities. For instance, Javika, a famous ayurvedic physician in Buddhist legends, underwent professional training for seven years at the University of Takshasila (Bala, 1991:39). Ayurveda was a subject of study in the universities of Takshasila (2nd century B.C.) and Nalanda (7th century A.D.), and many well-known personalities from different countries such as Japan and China received training in these two universities. The University of Takshasila attracted medical students from far and near and all the specialities in medicine and surgery were highly developed even at that time (Ministry of Health, 1958:1). Nagarjuna, an alchemist of ancient India, made many chemical experiments in ayurvedic mineral preparation and made many discoveries in the 2nd Century A.D. (Ministry of Health, 1958:1). Susrut claimed that surgery made significant progress at that time and young students did experiments with various fruits and vegetable under the guidance of senior practitioners in order to gain practical knowledge on surgical interventions (AYUSH Yearly Calendar, 2004).

Ayurvedic professional training shifted to the houses of famous *vaidyas* after the 10th century A.D., and students were trained at the *vaidyas*' houses as young apprentices (Ministry of Health, 1958:1). An attempt to revive ayurvedic education in formal modern training institutions was fostered during the British colonial rule.

This chapter examines ayurvedic education and argues that the nationalist revival of ayurveda reproduced colonial hegemony. The post-colonial state restructured traditions instead of reviving traditional ayurvedic education, training and apprenticeship. Modern-day ayurvedic practitioners perceive ayurvedic training from the Western allopathic outlook. The chapter begins by examining the historical evolution of ayurvedic education up to the present day. In particular, it focuses on undergraduate education and explores how new educational arrangements reproduce colonial hegemony in post-colonial Indian society.

Evolution of ayurvedic education

In the ancient past, the Rishis and Munis (legendary early ayurvedic practitioners) who practiced and popularised ayurveda are represented as teaching their students under the shade of trees, near to forests or in open areas, surrounded by mountains, for two major reasons. Firstly, ayurveda was based on herbal-natural materials and these raw materials for preparing medicines were accessible in the mountains and forests. Secondly, ayurvedic healing involved religious and spiritual treatment. Living close to forests and mountains was considered an advantage for the spiritual concentration of practitioners and for gaining deep knowledge of medicinal plants and herbs. The compilers of the ayurvedic texts, Charok and Susrut, were also used to lead a natural lifestyle.



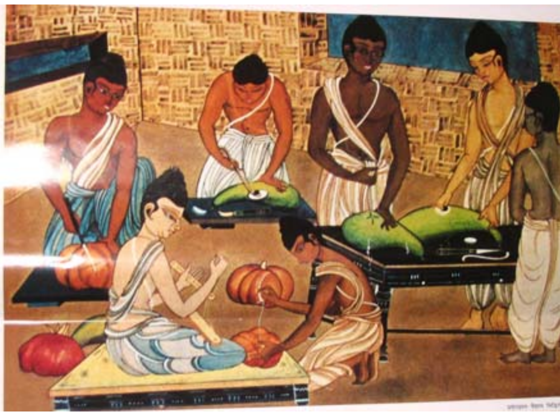


P 5.1 Punarvasu Atreya (2000 B.C.), original expounder Agnivesh Tantra (*Charok Samhita*), with his students.

P 5.2 Charok (Redactor of *Charok Samhita* and of physician to King Kanishka) teaching ayurveda

Source: AYUSH Yearly Calendar 2004

The training of the *vaidya* in the early days followed Brahminical religious lines. The student usually lived in the home of his guru (master) as a junior member of the family, and gradually they developed an intimate personal relationship with each other (Basham, 1976). The young medical student became linked with his teacher by supernatural and eternal bonds (Basham, 1976). After being accepted by the guru to study ayurveda the young student was treated as 'thrice-born' (*trijonmo*), which distinguished him from the ordinary brahmin, who was only twice-born (*djonmo*) (Basham, 1976). The guru required the young student to be honest, to follow vegetarianism, and to obey him during his studentship (Basham, 1976). A student was entitled to use the title *vaidya* and was allowed to conduct normal medical practices after the successful completion of training. He could then leave his guru's house and establish his own professional territory (Basham, 1976). This tradition of education continued until the mid-nineteenth century, when the British colonial administration intervened.



P 5.3 Young ayurvedic surgeons undergoing practical surgical training with various fruits and vegetables.



P 5.4 Experimental surgical training on various models, as described by Susrut.

Source: AYUSH Yearly Calendar 2004

In 1822 the colonial administration founded the School of Native Doctors in Calcutta on Western allopathic lines, where lectures were given on modern (allopathic) medical subjects side by side with ayurveda. The assumption here was that, while the native indigenous practitioners were already knowledgeable about ayurveda, they also needed to learn allopathy. However, a committee was appointed by the British Governor General Lord William Bentinck to evaluate the program, which reported that the training program was defective and recommended its immediate abolition (Ministry of Health, 1958). Hence, the School was abolished and an allopathic medical college was opened in Calcutta in the year 1835. After that, the training course in ayurvedic medicine was transferred to various Sanskrit colleges. At the beginning of the twentieth century, ayurveda was separated from the Sanskrit colleges and many independent new ayurvedic teaching institutions were established in various parts of British India. However, most of the newly-founded ayurvedic training institutions adopted integrated education curricula, where some courses from the

allopathic medical sciences were taught side by side to ayurvedic courses (Ministry of Health, 1958:25).

Reviving ayurveda and replicating colonial hegemony

Chatterjee noted two strategies that the colonial state followed in India to create legitimacy for its rule. The first was through alliances with the traditionally dominant class, who gave their consent to justify colonial rule, which was also imperial by nature. The second was a matter of "taking over the signs of imperial authority" (Chatterjee, 1994:80). British imperial authority, in order to justify its legitimacy, applied two techniques, which were fairly common in the colonized countries. First was the incorporation of the indigenous economic system into the global network of capitalism through the restructuring of the production and exchange sectors; second, introduction of the procedures of law and administration and institutionalization of the "rational bureaucratic norms" developed in Europe during the enlightenment period (Chatterjee, 1994:81-82). Gradually, those institutional norms were shared by increasingly large sections of the urban middle class and became a hegemonic project of the colonial state, in which Western education was used as chief instrument (Chatterjee, 1994:83). Chatterjee concluded that "If the hegemonic project of colonial state required the transformation of indigenous tradition into the universal forms of a rational and scientifically ordered social life, then it was the new intelligentsia among the colonized which emerged as the crucial mediating agency, turning the external force of the colonial critique of indigenous tradition into an internal critique" (Chatterjee, 1994:83).

The All-Indian Ayurved Mahamandal and the Indian National Congress on Ayurveda (1920-38) made one of the earliest nationalist attempts to revive ayurveda in the early part of the twentieth century. The Indian nationalist leaders strongly supported the revival of ayurveda towards the end of British rule. Subsequently, the Indian National Congress adopted a resolution to further popularize ayurvedic schools, colleges and hospitals. As a result, ayurvedic schools and colleges were opened in various major cities in India such as Varanasi, Madras, Delhi, Bombay and Mysore, and in the state of Bengal. All these efforts led to an increase in the number of such institutions, from 15 in 1920 to 30 in 1935 and to 50 by the time of Indian independence in 1947. At a conference of health ministers of various states in 1946, the delegates strongly recommended offering diploma and degree courses and the introduction of ayurvedic post-graduate courses for the graduates of allopathic medicine (Ministry of Health, 1958: 2).

In the year 1946, the Chopra Committee directed that ayurvedic education be better coordinated and integrated with allopathic medical education, and this was another landmark in ayurvedic education. By 1958 there were 76 institutions in India teaching ayurveda, 49 of which had adopted integrated education. The universities of India were also considering making affiliation with ayurvedic teaching institutions around this time, and some of the ayurvedic educational institutions offering integrated course were already affiliated to universities (Ministry of Health, 1958). Academic control of the remaining teaching institutions was monitored by the various boards of the different state governments, such as Paschim Bangla Ayurvedic Parished, which was monitoring the ayurvedic educational practice and registration issue in West Bengal (Ministry of Health, 1958: 26).

It is possible to categorize ayurvedic training according to three types of training systems. There is the apprenticeship system, in which traditionally-trained practitioners are trained under the guidance of an ayurvedic guru. Most practitioners choose this system because of family tradition or involvement in the ayurvedic profession. They had to register, with the status of medical practitioner, according to the regulations of the Indian Medicine Central Council Act, which came into force in 1970. There is also a second category of institutionally-trained ayurvedic practitioners, who hold the Bachelor of Ayurvedic Medicine and Surgery (BAMS) degree. Thirdly, there is now postgraduate training in ayurveda leading to the Doctor of Medicine in Ayurveda (MD Ayurveda) degree. The practice is regulated through the Indian Medicine Central Council Act 1970 and both institutionally qualified and traditionally trained practitioners are recorded in the registers maintained by the Central Council of Indian Medicine (CCIM).

Undergraduate education involves a course curriculum and training schedule for five and a half years, including one year of clinical internship, whereas postgraduate courses last for three years. About 209 undergraduate and 59 postgraduate colleges/institutions/universities were registered under the Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homeopathy (AYUSH) of the Ministry of Health and Family Welfare, Government of India by 2002 (AYUSH, 2003:94-200). Apart from graduate education, there are also 14 institutions all over India that offer pharmacy-training courses in ayurveda (AYUSH, 2003:217-218). In 2003 there were 432,625 AYUSH registered practitioners, including 333,742 institutionally-qualified, and 98,883 non-institutionally qualified, practitioners of ayurveda (AYUSH, 2003:88). There were also 7,772 licensed pharmacies under

AYUSH manufacturing ayurvedic drugs (AYUSH, 2003:211). Ayurvedic drug manufacturers are licensed and regulated under the Drugs & Cosmetics Act, 1940.

In the current ayurvedic syllabus for undergraduate education, prescribed by the Central Council of Indian Medicine (2003-2004), students need to attend 18 courses for four and a half years training (excluding the one-year internship). These are as follows: for the First Professional Examination (one and a half years), History of Ayurveda, Padartha Vijnana (physics), Sanskrit, Astanga Samgraha (eight branches of ayurveda), Sarira Racana Vijnana (anatomy), Kriya Sarira Vijnana (physiology); for the Second Professional Examination (one and a half years), Svastha Vrtta (hygiene), Dravya Guna-Vijnana (discussion of drugs), Rasasastra and Bhaisajya Kalpana (ayurvedic pharmacology and chemistry), Roga Vijnana and Vikrti Vijnana (pathology), *Charok Samhita*, Agada Tantra (toxicology) and VyavaharAyurveda ka Vidhi Vaidyaka (jurisprudence); and for the Third Professional Examination (one and a half years), Prasuti Tantra and Striroga (obstetrics and gynaecology), Kaumarabhrtya (paediatrics), Kayacikitsa (internal medicine), Salya Tantra (surgery), Salakya Tantra, and Charok Samhita.[24] Clinical internship is the final phase of training, and a graduate is expected to conduct actual practice of medical and health care and acquire skills under supervision so that he/she may becomes capable of functioning independently.

[24] Central Council of Indian Medicine (2003-04) B.A.M.S. curriculum and text books, No.3:3-56 (2003-04) (Translator Vd. Pawankumar R. Godatwar). New Delhi: Central Council of Indian Medicine.

Research on ayurveda

Apart from undergraduate training, there has been a revival in research on various aspects of ayurvedic medicine. The Central Council for Research in Ayurveda and Siddha (established in 1978) is a primary body for the formation, coordination, development and promotion of research on ayurveda and *siddha*. The Council has 34 institutes/units including its headquarters (AYUSH, 2003). Out of the 34 research institutions, 24 do research on ayurveda - in Calcutta there is the Central Research Institute (Ayurveda). The Central Council of Research is involved in various activities, including clinical research, the survey and surveillance program, the community health care program, and the tribal health care program (CCIM Web page). The Council has carried out clinical studies on *vishama jvara* (malaria), *apasmara* (epilepsy), *vata vyadhis* (neuromuscular disorders), *tamak shvasa* (bronchial asthma), *parinamsula* (peptic ulcer), *yakrit roga* (liver disorder), *paurush granthi vriddhi* (enlargement of prastate), *mutrashmari* (urolithiasis), *arbuda* (cancer), *kitibha* (psoriasis), *medoroga* (obesity), *hridroga* (ischemic heart diseases), *kamala* (infective hepatitis), etc. (CCIM Web page). It has also been involved in drug research, including medico-botanical survey, cultivation of medicinal plants, a pharmacognostical research program, plant tissue culture, a chemical research program, a pharmacological research program, toxicological studies, a drug standardisation research program, and a musk deer breeding program (CCIM Web page). In addition, the Council has been involved in the publication of rare and classical manuscripts of ayurveda, of a scientific journal/bulletin, a newsletter, and pamphlets on their research findings (CCIM Web page).[25]

[25] For details of research activities on ayurveda in contemporary India please visit Central Council of Indian Medicine (CCIM) webpage.





P 5.5 Central Research Institute (Ayurveda) **P 5.6** Sign board of a research scheme in CRI

Source: Photos were taken by the author during participant observation in the CRI

There were 53 public and 156 private ayurvedic colleges for undergraduate education in India in 2003; and 30 public, and 29 private, colleges for postgraduate education; thus ayurvedic colleges were operated and funded by private initiative (AYUSH, 2003).

Table 5.1

Yearly numbers of registered ayurvedic practitioners under AYUSH[26]

Year	Institutionally Qualified [27] /With Formal Qualification	Non-Institutionally Qualified/Apprenticeship-based	Total
1980	88,265	83,893	220,497
1981	95,497	87,567	232,227
1982	85,227	99,373	233,824
1983	86,844	95,064	232,190
1984	93,340	95,395	243,153
1985	100,085	96,319	251,071
1986	108,753	101,224	264,800
1987	115,427	101,253	271,696
1988	185,701	100,804	306,740
1989	194,589	100,652	315,719
1990	216,344	100,926	337,966
1991	235,388	103,254	339,200
1992	243,537	110,328	354,423
1993	243,347	110,019	353,924
1994	245,553	109,131	354,684
1995	251,262	104,554	355,816
1996	254,538	104,026	358,564
1997	261,906	98,384	360,290

[26] Total IQ and NIQ registered practitioners of ayurveda may not tally for some years as break-up has not been furnished by some States/Uts.

[27] The terms Institutionally Qualified and Non-Institutionally Qualified are used by the AYUSH report

1998	265,743	98,142	363,885
1999	270,349	98,148	366,812
2000	330,576	96,928	427,504
2001	333,956	96,934	430,890
2002	332,372	97,891	430,263
2003	333,742	98,883	432,625

Source: AYUSH, 2003:89

In 2003, the number of those with formal qualifications as ayurvedic practitioners increased to 3 33,742, nearly 3.8 times higher than it had been in 1980 (88,265). However, the number of those trained predominantly under the apprenticeship system (Non-Institutionally Qualified) had not increases proportionally, as in 1980 there were 83,893 apprenticeship-based practitioners and in 2003 only 98,883. Apprenticeship-based ayurvedic practitioners were predominantly located in rural areas and often provided health care services where no other health care facility was available and living in the communities they served. Many of them produced ayurvedic medicine for treatment; while those with formal degree qualifications prescribed commercially-manufactured drugs to their patients. However, some apprenticeship *kabirajes* are very popular in urban areas and provide health care services for the middle class elite, although most of these have formal training in addition to that of the apprenticeship tradition. They usually come from traditional *vaidya* or *kabiraj* families, and today most are old.

Perception of modern ayurvedic education

The formalization of the ayurvedic education system and its curriculum have brought mixed responses from the practitioners and students. Out of the 20 physicians and 20 students surveyed in 2004-2005, 65% of the physicians and 80% of the students respectively perceived the current ayurvedic curriculum and the introduction of the BAMS course favourably, while 30% of the physicians and 20% of the students feared the dilution of ayurvedic contents. Those who favoured the new education curriculum argued that the ayurvedic system needed to adapt to modern demands and that the old apprenticeship was no longer appropriate in modern Indian society. Furthermore, they felt that the adoption of technology and scientific knowledge would enable the ayurvedic system to modernize and globalize. The need to modernize the outdated system of apprenticeship (*guru-mukhi-vaidya*) is echoed by one of the physicians:

> "When I was a student I thought about ancient ayurvedic teaching and learning, where a guru taught four-five students. However, he could not teach beyond his own knowledge. In the *guru-mukhi* system, four or five students worked under a physician, lived in his house, became familiar with the plants, trees, herbs, patients, diseases, treatments, etc. from the guru. It sounds good but I feel that a physician cannot be an expert in all areas. If a physician has limitations in a particular area, it will affect his students. One the other hand, the contemporary education system recognizes different experts to teach various subjects. For example, there are five experts with the same qualification but with specialization in internal medicine, gynaecology, chemistry etc. This recognizes the individual's interest and expertise to teach in a particular area. The contemporary system also creates a scope to do specialization in a particular area, which is called Doctor of Medicine (MD). I think that ayurvedic education is more systematic under the current form of training. Some allopathic medical education has been incorporated in the current ayurvedic education curriculum. Ayurveda has a history and allopathic medicine has its own history and we must learn both" (AP4).

However, there continues to be dissatisfaction with the current ayurvedic curriculum. Of those surveyed, 90% of the *kabirajes* noted that there was room for improvement. Others commented on the market orientation of the ayurvedic practitioners, whose goal is to obtain good jobs and good salaries. One said that:

> "There are many aspects of the BAMS course syllabus which are not implemented. For instance, pulse-checking science. It was written in the BAMS syllabus, but no practical attempt has been made to teach the students here. There is limitation of skilled expertise to teach *Charok Samhita* here. There is no such sound practice on *kharsustro* (*panchokormo*). Now the ayurvedic education has become very market-oriented. After obtaining the degree, students look for a job. But the real ayurvedic treatment or practice was not job-based (monthly salary) by tradition. It was based on the practice and expertise of a particular ayurvedic *kabiraj*. None of the renowned *kabirajes* did salary-based jobs in any ayurvedic hospital or dispensary or drug company. They developed their own practice from their own clinic, gained expertise and earned huge amounts of money, which made people jealous. Current BAMS curriculum is nearly similar to the MBBS syllabus, and there are some overlapping courses. Although anatomy, physiology, etc., existed in ayurveda, students are more exposed to learn allopathic anatomy and physiology. Actually the basic space of ayurveda was destroyed by the two hundred years foreign rule or occupation" (AK6).

Ayurvedic education in Bengal

Apprenticeship ayurvedic system in Bengal

In Bengal, the apprenticeship system is known as *guru-mukhi-biadya*. In Bangla language (or Bengali), a *guru* is a knowledgeable person, mukhi means centric, and *biadya* means knowledge. Thus, *guru-mukhi-biadya* refers to learning knowledge from a particular knowledgeable person who acts as a master. The tradition of ayurvedic learning under the *guru-mukhi-biadya* system continued in Bengal until the

establishment of the Central Council of Indian Medicine (CCIM) in the 1970s by the Indian parliament. After the foundation of CCIM, only those ayurvedic practitioners trained in modern ayurvedic institutions got the right to become registered ayurvedic practitioners. The newly-founded council declared it obligatory for an ayurvedic practitioner to become registered under the council in order to continue practicing, which limited the right of practitioners trained under the apprenticeship system. As the graduates trained under the apprenticeship system did not get the right to become registered practitioners, this system was eventually abolished, although the gradual decline of the apprenticeship system had begun in the mid-nineteenth century, when modern medical colleges were founded in India.

Under the apprenticeship system, the guru (master) had a *toll* (school) in his house where junior students got practical training in ayurveda. As previously mentioned, usually the students lived at the master's house as junior members of the family, or in the same community, so that they could stay in touch with their master. The guru, or ayurvedic physician, used the title *kabiraj* and taught the students from ayurvedic texts written in Sanskrit. Gupta notes that, in the *toll* system, the guru or ayurvedic *kabiraj* trained his apprentices without demanding private tuition fees and that "the relationship between the kabiraj and student was that of a guru and disciple" (Gupta, 1976:368). Students were first instructed in Sanskrit grammar, literary texts, and logic, and gradually completed the preliminary course related to classical medical texts (Gupta, 1976). As it was hardly possible for a teacher to go through all the topics from the classical texts within a short period of time, "students were made familiar with the basic knowledge of their guru, and later on they could read the other topics themselves" (Gupta, 1976:368-369). According to a general code of treatment, the

kabiraj would investigate the patient's illness and general state of health and observe the appearance and behaviour of the patient. Finally the *kabiraj* would examine the pulse, eyes, abdomen, and tongue of the patient according to his traditional skill and expertise (Gupta, 1976). The young students also observed their master's diagnosis and learne the treatment methods and modalities. Apart from theoretical training, students assisted the kabiraj when patients visited him, and they accompanied their master to homes to treat severely ill patients in order to gain clinical experiences (Gupta, 1976:369). The kabiraj or master also taught the students on the knowledge and preparation of herbal remedies and the use of herbs and plants for medicine.

Table 5.2

The leading schools/*tolls* of traditional ayurveda in nineteenth century Bengal[28]

School/*toll*	Special virtues of the school
East Bengal	
Savar	Preparation of herbal medicines
Matta	Techniques of examining patients, diagnosis, and prescriptions
Gaila	Preparation of medicines and Chemotherapy
Chandsi	Healing many kinds of ulcers, fistula, and piles
Chittagong	Treating insanity
Khandarpara	Treating insanity and constructing temporary huts like temporary hospitals
West Bengal	

[28] This table is taken from the article "Indigenous medicine in Nineteenth and Twentieth century Bengal", by Brahmananda Gupta, 1976

Mursidabad	Reading pulse and diagnosis
Kumartooli	In medicine
Srikhanda	General physicians who sold medicines in the open market and who published ayurvedic text books

(Gupta, 1976:369)

Under the apprenticeship system, each of the *kabirajes* tended to specialize in one area of treatment, and some gained great fame in their areas of specialization. Most of these *kabirajes* established their own *toll* (school). The *toll* functions as an institution to promote the skill and fame of that *kabiraj* who founded and operated it. Those trained under these *kabirajes* would stand a good chance to attract patients to them. After graduation, most of these students would leave the *toll* and start their own practices.

Unlike formal education systems, apprenticeship training does not have a specific time period for completion of the training. In most cases, it depends on the individual student's capability to learn, and sometimes it might take many years of training before he is deemed to be proficient by his master. After years of practice and becoming known, the student would found his own *toll* and teach new students. However, students always regard the contribution of their guru as having contributed to their success, no matter how famous and popular they become in professional life. One *kabiraj* who had learned ayurveda in a *toll* stated:

> “I have been practicing ayurveda for the last 65 years because of my family profession. I learned pure ayurveda from a *toll*, because ayurvedic colleges at that time offered integrated ayurvedic course with allopathy. I am particularly grateful to my Guru Deb (master) Sri Jogendronath Dorshon Sastri who did not only give textual knowledge but also took me with him to attend many complex patients in different parts of the country and teach me the practical knowledge. I accompanied him as an assistant physician and gained clinical experience. I observed many complex treatments done by my Guru Deb and gained experience. My father, grandfather and uncle were also *kabiraes*. All these experiences made me proud and confident to treat patients. The skills of an ayurvedic *kabiraj* are god-given. Institutional training never can produce a successful ayurvedic *kabiraj*” (AK 6).

Among those *kabirajes* who became famous for their specialized treatments and established their own *tolls* during the nineteenth and twentieth century in Bengal were: Kabiraj Ganggadhor Sen (1798-1885), Kabiraj Ganggaproshad Sen (1824-1895), Kabiraj Darkanath Sen (1843-1909), Kabiraj Haran Chandra Chakroborti (1849-1935), Kabiraj Bishonath Sen (1853-1901), Kabiraj Abinash Chandra Gupta (1858-1924), Kabiraj Bijoy Rotno Sen (1858-1911), Kabiraj Zogininath Sen (1871-1931), Kabiraj Shamadas Baspoti (1864-1934), Kabiraj Gononath Sen (1877-1944), Kabiraj Sattochoron Sen (1878-1933), Kabiraj Zamini Bhushon Roy (1879-1926), Kabiraj Zogendrnath Dhorshon Tirtho (1883-1969), Kabiraj Baneshor Kabbo Tirtho (1886-1940), Kabiraj Nir madhod Roy and his son Kabiraj Onat Roy (1888-1970), Kabiraj Shideshor Roy (1892-1967), Kabiraj Shamadas Roy (1892-1966), Kabiraj Zotindromohon Torko Tirtho (1893-1977), Kabiraj Bimolanando Torko Tirtho (1897-1986), Kabiraj Romesh Charndro Sen (1894-1962), Kabiraj Amola Charon Sen (1896-1979), Kabiraj Bijoy Kali Bhatacharzo (1900-1971), Kabiraj Monindro Lal Das Gupto (1897-1970), Kabiraj Indu Bhushon Sen (1901-1964), Kabiraj Shudhinnath Roy (1902-1962), Kabiraj Shusil Kuam Sen (1902-1991), Kabiraj Surzokanto Roy

(1914-1991), Kabiraj Zadobeshor Acharzo (1904-1983), Kabiraj Monoronzhon Pakrashi (1905-1969), Kabiraj Shibkali Bhartacharjo (1908-1992), and Kabiraj Premanando Das Gupto (1909-1979) (Sutanuti Porishod, 1999).[29] A majority of the above kabirajes had their own *toll* to teach junior students although a few of them were keen to establish modern ayurvedic colleges. For example, Zamini Bhushon Roy founded Jamini Bhushan Ashtanga Ayurvedic College in the year 1916, and Shamadas Bashpoti founded Shyamadas Vaidya Shastra Pith to provide higher education in ayurveda in Bengal. However, all of them had gained the basic knowledge of ayurveda through the apprenticeship system, and some produced successful successors from their *tolls*.

Modern ayurvedic education in Bengal

In spite of the fact that Bengal was one of the most important places for ayurveda, the recent situation is not too optimistic. In 1958, there were five institutions that provided ayurvedic training. These were Jamini Bhushan Ashtanga Ayurvedic College, Shyamadas Vaidya Shastra Pith, Vishwanath Ayurveda Mahavidyalaya, Arya Vaidya Pratisthan, and Vaidyak Pathshala in Midnapore[30]. Training in ayurveda at that time was confined to a few government-aided or private institutions.

[29] This list of renowned *kabirajes* was collected from a *sharok pustika* (manual text) published by the Sutanuti Porishod, Shampur regional branch, Calcutta, 25 May 1999. The original text was published in the Bangla language.

[30] For the recommended syllabus for undergraduate education in these institutions please see the Government of India, Ministry of Health Report of the Committee to assess and evaluate the present status of Ayurvedic system of medicine 1958:210-212.

In 1835, Calcutta Medical College had been founded for Western medical education in India, with 50 stipendiary, and the training period was from four to six years. In 1860, Western medical education was handed over to the Calcutta University, which offered a Licence in Medicine and Surgery (LMS) and an MB (Bachelor of Medicine) degree (Ministry of Health, 1958: 20). In recent decades, only the MBBS degree has been recognized as the minimum medical qualification, in order to establish uniformity in medical education (Ministry of Health, 1958: 48). In the mid 1970s the government introduced a degree in ayurveda, the BAMS (Bachelor of Ayurvedic Medicine and Surgery). This degree is the equivalent to the MBBS today, and both degrees have equal status and are recognized by the government and the public.

In Bengal, the most significant place for ayurvedic training is now the Jamini Bhushan Ashtanga Ayurvedic College, which has been renamed Jamini Bhushan Roy State Ayurvedic College and Hospital. Only recent years have we witnessed the establishment of the privately-founded and governed Rajib Ghandhi Ayurvedic Memorial College & Hospital. In addition, there is Shyamadas Vaidya Shastra Pith, which is an institute for post-graduate ayurvedic education. Both these public institutions are situated in Calcutta. During the British colonial rule, J. B. Roy Ayurvedic College offered an integrated medical education, combining both allopathic and ayurvedic education and subjects in the syllabus. The graduates were required to do both the allopathic and ayurvedic practices. After affiliating with Calcutta University in 1976, the syllabus was re-organised, and only[31] the ayurvedic course curriculum has been taught, with graduates of this program obtaining the

[31] Although there has been debate about the curriculum.

BAMS (Bachelor of Ayurvedic Medicine and Surgery) degree. In recent years, the college has come under the management of the West Bengal Health University.

Students taking a degree under the integrated ayurvedic education curriculum during 1950s were required to take 12 individual subjects in anatomy, physiology, fundamental principles of ayurveda (i.e., ayurvedic *sharir)* and their philosophical approach in relation to *darshanas* (ayurvedic philosopgy), pharmacology and therapeutics, *dravya guna* (discussion of drugs), Rasa Shastra and Baishajya Kalpana (ayurvedic pharmacology and chemistry), pathology and bacteriology, modern medicine, surgery, midwifery and gynaecology, medical jurisprudence, Rog nidana and Chikitsa (disease identification and treatment), Swastha Vritha (i.e. preventive medicine) (Ministry of Health, 1958).[32] In West Bengal, during the post-independence years, only one additional ayurvedic college was established, under private management.

[32] For details of the recommended syllabus for undergraduate education please see the Government of India, Ministry of Health Report of the Committee to assess and evaluate the present status of Ayurvedic system of medicine 1958:50.

Table 5.3

List of ayurvedic educational institutions in West Bengal

Type of college	During the British rule	After the Indian independence[33]	At present (Total)
Ayurvedic	5 1. Jamini Bhushan Ashtang Ayurved Vidyalaya (1916) 2. Shyamadas Vaidya Shastra Pitha Parishad 3. Vishwanath Ayurveda Mahavidyalaya 4. Arya Vaidya Pratisthan 5. Vaidyak Pathshala, Midnapore	1 1. Belley Sankerpur Rajiv Gandhi Memorial Ayurved College and Hospital (2002)	3 1. J. B. Roy State Ayurvedic College and Hospital (1916) 2. Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith 3. Belley Sankerpur Rajiv Gandhi Memorial Ayurved College and Hospital (2002)

[33] After Independence 3 ayurvedic institutions in West Bengal - Vishwanath Ayurveda Mahavidyalaya; Arya Vaidya Pratisthan; and Vaidyak Pathshala, Midnapore - were closed.

Educational background of the ayurvedic physicians and *kabirajes*

Of those surveyed, all 20 ayurvedic physicians had basic knowledge of allopathic medicine, as they had got professional training at different stages of their academic qualification BAMS courses, internships, and MD courses. While there is no separate hospital for doing internship for the undergraduate ayurvedic students in West Bengal, the students inevitably did their internship training in the three allopathic hospitals. During housetop-ship (residency) they practiced allopathy in an ayurvedic hospital.

Table 5.4

Educational attainment of ayurvedic graduates (those interviewed)

Degree of the Ayurvedic Physicians			
BAMS	BAMS, MD	BAMS, MD, PhD	
20	10[34]	2	
Specialization			
Kayachikitsha (Internal Medicine)	*Drobbogun* (Pharmacology)	Medical plants	*Krimirog*
5	3	1	1
Practice of profession			
Work at govt. institutions and don't attend private patients	Work at govt. institutions and attend private patients	Work at private institutions and attend private patients	Total
5	6	9	20

[34] Out of the 20 physicians having BAMS degree, 10 pursued further postgraduate course leading to the Degree of Doctor of Medicine (MD) and 2 physicians completed both the MD and PhD course.

Eight elderly *kabirajes* had had formal institutional training in addition to their apprenticeship backgrounds; they had all come from traditional ayurvedic families, and this had grounded their apprenticeships in their family backgrounds. Two had studied in *tolls*, and had only completed the apprenticeship system; both of these were more than 90 years old. Two had the Ayurved State Faculty (ASF) diploma, which was a 3-year ayurvedic programme after secondary education. Four had the Member of Ayurved State Faculty (MASF) degree, which was a five-year integrated degree programme. For this programme, students studied ayurveda for 3 years, followed by 2 years of allopathic training. The MASF course later became equivalent to the Bachelor of Ayurvedic Medicine and Surgery (BAMS) course. Of those surveyed, one had the MASF, MD and PhD degree, while one had the Ayurved Acharja degree which is equivalent to the MASF. Ayurvedic graduate degree was titled differently in various states of India before the introduction of the BAMS course - for instance, MASF in West Bengal, Ayurved Acharja in Bihar. Only BAMS course is being offered in India today as undergraduate degree programme.

Present-day status of ayurveda in West-Bengal

While the state government of West Bengal has been attempting to popularise ayurveda, students and practitioners are dissatisfied with a lack of progress in modernizing ayurveda to suit modern needs. One of the main problems mentioned by the students and practitioners is the outdated ayurvedic curriculum taught at the

college. 45% of the students regarded the BAMS course curriculum as outdated[35]. Some of the students' comments follow.

> "Our syllabus should be modernized and we need a comprehensive and comparative syllabus with allopathic medical science. We are still studying *bayu-pitto-caugh* (air, bile and phlegm) as the central principle of ayurveda, which has no practical value today while modern pathology has developed to the highest stage. We need to exclude those topics and adopt biochemistry from allopathic medical science. We are studying the number of veins or pulses in the human body. Obviously it had an importance during olden days but not today. Science has made significant progress and many aspects of olden ayurveda are inapplicable today and need further modernization or modification" (AS18).

> "We have a combined syllabus of ayurveda and allopathy. As a result, students can't understand what to study and how to study or how much modern medical science and how much ayurveda needs to be studied? Since ayurveda does not have emergency medicine we have to study modern pharmacology, anatomy and physiology, pathology, etc. Simultaneously, we also have to know the ayurvedic pharmacology (*roshoshastro)*. It becomes very difficult for a student to complete both the courses at a time - that was a major problem I encountered. We know a little of ayurveda and little allopathic medical science, and become masters of neither ayurveda nor allopathy." (AS19)

Another factor that has impacted on the choice of students to study ayurveda is the language barrier - as noted by 25% of the students surveyed. Ayurvedic materials were originally written in Sanskrit and most of the available publications and reading materials are in Hindi. The Bengali students found it difficult to read subjects in Hindi or Sanskrit. It was especially difficult when a teacher taught ayurveda in Bangla due

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[35] For the comparative table about examination system between BAMS course and MBBS course please see appendix 6

to his/her poor oral skills and expertise in Hindi, while the prescribed readings for the students were in Hindi. There are many terms and narratives they found difficult to understand, and students found it difficult to understand the deep knowledge of ayurveda because of their poor or lack of language skills. They found topics, such as *Sharir Kira* (ayurvedic physiology), *Sharir Rochana* (ayurvedic anatomy), *Astango Shangraw* (eight branches of ayurveda), *Sanskrit*, *Padartho Biggan* (physics), *etc.*, totally unfamiliar. Students found it difficult to bridge the gap between these indigenous forms of medical practice and those of the modern Western scientific allopathic system that they have been exposed to and are familiar with.

Furthermore, the lack of qualified and dedicated teachers and infrastructure, including library resources, served to further alienate potential students from studying ayurveda. To date, there is only one ayurvedic public college, which has produced only 60 graduates, in the entire West Bengal state. Furthermore, the fact of only small numbers of patients in the ayurvedic hospital hinders ayurvedic medical interns and students in their clinical practice. Finally**,** government negligence was also mentioned by a significant number of students. Although ayurveda focuses primarily on herb and plant-based medicine for its pharmacology, there was no herbal garden within the college campus. As a result, many students could not identify the medicinal plants. All these factors led to frustration and disillusion on the part of the students, and many moved away from this form of training[36].

While the students were dissatisfied with the slow rate of change, the practitioners found the professionalization of ayurveda to their advantage. Of those

[36] For the facilities available for treatment in ayurvedic system of medicine in West Bengal please see appendix 7

surveyed, 70% of the physicians realized that their status had been upgraded after taking part in the formal training program as a result of the modernization and professionalization of ayurveda, and there has been an increase in their interest in studying ayurveda., the status of the ayurvedic physicians and practitioners has risen considerably in recent years. However, in spite of the increase in status resulting from this professionalization and modernization, *kabirajes* continued to be highly regarded. As one physician stated:

> "If a patient is cured by a physician, he/she might show respect to the physician irrespective of the training background of the physician. As a physician, I think our status is equal to other physicians from other medical systems. However, it is also important to explore the patient's or people's view, whether they consider us as similar to physicians from other systems. My experience suggests that middle class people tend to understand more about ayurveda and respect the ayurvedic physicians. On the other hand, illiterate people/patients put their trust in allopathic physicians" (AP7).

In addition to the physicians' views of ayurveda, it is imperative to note here the views of the patients. It is to be noted that the majority of the patients, the main bulk of whom are from the rural and wealthy classes, do not pay much attention to the training background or qualifications of the ayurvedic physicians. The fame of the physician is related to his medical skill, and such is often spread through by word of mouth by those patients who have been cured by these *kabirajes*. The family tradition of the *kabiraj* also brings unprecedented popularity in the community. Generally, famous *kabirajes* had more patients than the young generation of physicians. Only those from the middle or professional classes paid more attention to formal and professional training. Of those surveyed, 65% had not been aware of the professional qualifications of their own ayurvedic practitioners before visiting them.

‘Quack’ practices

‘Quack’ is a negative term, and a quack practitioner is not well respected by the health officials or modern physicians. Although many quack practitioners provide much needed health care services in the rural areas they are disrespected by both the private and public health authorities. Quack practice is illegal in India. However, quack practitioners are accepted by rural communities. There was a mix of feelings among patients surveyed in this study about quack practices. Some patients perceived quack practitioners as bearers of negative reputation for ayurveda and preferred that they be regulated. Others suggested that the quack practitioners should undergo a short training course before being allowed to practice. They regarded some practitioners in rural settings as having been well trained through the apprenticeship system (the traditional *kabiraj* system, or apprenticeship to non-registered practitioners) and as providing very good health care. As one traditional *kabiraj* said:

> “The experience and knowledge of traditional practitioners made them popular and effective. Institutional education was not the only consideration for becoming a successful ayurvedic practitioner. Many of the young ayurvedic physicians were not clear about how the old practitioners did treatment. They know the textual issues, although many aspects of ayurveda exist beyond the book. The physician’s behaviour towards patients was another consideration, as some of the qualified practitioners showed inconvenient behaviour with poor patients. They always rushed with visiting fee. Many quack practitioners in the rural areas did not have such fixed visiting fees” (AK 6).

Another group of respondents among those surveyed noted that every medical system, including allopathy, homoeopathy, unani, ayurveda, etc., has quack practitioners. Others contended that some quack practitioners did not belong to any particular medical system but used drugs from various medical systems together.

Recent development

One of the major trends of ayurvedic education in recent decades is the entry of female students. In the past, there was very minimum entry of women into the ayurvedic profession. Ayurveda as a medical system considered women primarily as patients. It was only during the nineteenth-century British East India Company rule, when European missionaries started health aid activities in India, that a few Western women were involved as medical practitioners to provide health care. Given the fact that many local Indian women refused to consult a male medical practitioner, female missionary doctors had the advantage of access to female patients (Jayawardena, 1995:77). But the social ideology was still a burden preventing Indian women from engaging in the medical profession.

Although Calcutta Medical College was founded in 1835 as a pioneer for Western medical education, it was only in 1918 that a Women' Medical College was founded. Before that, one of the earlier interventions to engage native Indian women in health care professions was the training program for midwives. A women's hospital was completed by the year 1902, while a nursing training school had already begun activities by 1900 (Jayawardena, 1995:78). However, all these initiatives to engage women in medical and health professions in India were concentrated on providing Western medical and health services.

Women's involvement in ayurvedic medical and health care services during the colonial era was very minimal and only became visible by the second quarter of the twentieth century. The Ministry of Health Report for 1958 published a survey result conducted among 76 ayurvedic educational institutions all over the country, in

which 54 institutions replied concerning male-female students' statistics. There were a total number of 7, 975 students enrolled, of which only 700 were female (Ministry of Health, 1958: 198-205). The report also mentioned that female students did not take up medical education, obviously because of the overall social circumstances. The report further noted that quite a large number of female students dropped out towards the end of their training period possible because "they are either not up to the standard or do not have the intention to settle down as practitioners". The report encouraged female students to choose the medical profession in large number, and to provide them with more scholarships to enrol in ayurvedic institutions, given to the fact that various fields, such as Gynaecology and Obstetrics, Paediatrics, etc., were underdeveloped in ayurveda. Especially in the rural areas, female Vaidyas had a useful part to play, and a large number of 'home- remedie' practices of ayurveda can best be carried out by female Vaidyas, the report added (Ministry of Health, 1958: 63).

In 1957, J B Roy State Ayurvedic College and Hospital[37] admitted 12 new female students and 134 new male students, a male-female student ratio of 11:1. In that year there was 1 female student out of a total number of 31 new students at the Institute of Post-graduate Ayurveda Education and Research at Shaymadas Vaidya Shastrapith[38] (Ministry of Health Report, 1958:205). However, the ratio of male to female students enrolled in undergraduate and post graduate educational institutions in Calcutta in recent time is approximately 3:1. The numbers of faculty members in 2004 were 32 males and 7 females at J B Roy State Ayurvedic College and Hospital;

[37] In 1957, the institute's name was Jamini Bhushan Ashtang Ayurved Vidyalaya, Calcutta, which offered a 4-year Ayurved Tirth degree.

[38] In 1957, the institute's name was Shyamadas Vaidya Shastra Pitha Parishad, Calcutta, which offered a 5-year MASF (Member of Ayurveda State Faculty) degree

while there were 7 male and 2 female lecturers in the Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith. The current data from the two educational institutions in Calcutta appears in Table 5.5.

Table 5.5

Male and female students and faculty in 2 ayurvedic educational institutions in Calcutta

	Undergraduate Institutions	%	Postgraduate Institutions	%
Male students	201	78%	23	77%
Female students	58	22%	7	23%
Male faculty	32	82%	7	78%
Female faculty	7	18%	2	22%

Source: Student attendance books in September 2004 at the J B Roy State Ayurved College and Hospital and the Institute of Post-graduate Ayurveda Education and Research at Shyamadas Vaidya Shastrapith during participant observation.

Another development is the adoption of ayurvedic patented drugs by allopathic physicians. It is now not uncommon for allopathically-trained doctors to prescribe ayurvedic herbal drugs because of their known effectiveness and minimum side effects. Drug stores selling allopathic medicines also carry patented ayurvedic drugs and health products. Many of these drugs do not require medical prescriptions and are readily available over the counter. It is thus not surprising that many Indians purchase

ayurvedic drugs over the counter when they are searching for alternative medicine for an illness. This has indirectly led to a revival in ayurvedic treatment.

As part of modern development, there has been a gradual trend towards integrated ayurvedic medical practice, which is known in Calcutta as cross-practice. It is now not unknown for ayurvedic practitioners to prescribe allopathic drugs and vice-versa. However, there continues to be resistance towards integrated practice. Of those surveyed, 80% were against cross practice and only 15% were for it; of those against, 50% belonged to the *kabiraj* group. However, 20% thought it important to understand other medical systems. An ayurvedic physician commented:

> "When our college was established in 1916, it started an integrated course and students studied both allopathy and ayurveda in parallel. As a matter of fact, students demanded registration to practice both systems after graduation. The Bengal Medical Council was in a dilemma and finally they decided to send the students for another two years' study in an allopathic medical college to get registration for allopathic practice. They provided a Diploma Licensing Condensed Medical Course (LCMC), and those who completed this course could practice allopathy. In 1964, the Indian government took over this college, as Government College. At that time, the allopathic doctors also taught here and the number of intake per year was unlimited. In 1971, ICM (Indian Council of Medicine) was formed to monitor the allopathy and CCIM (Central Council of Indian Medicine) was formed to monitor other systems of medicine - ayurveda, unani, homoeopathy, etc. At that time, there was discussion over the inclusion of Western medical courses in the ayurvedic syllabus. In 1976, the Calcutta University took over this college and only the ayurvedic syllabus was adopted. When I was a student at Ayurvedic College, I studied anatomy, physiology, pathology and some other subjects taught in the allopathic system. It is only because we have to know what the other medical systems are prescribing when attending their patients. As most of the patients visit ayurvedic physicians as final or second choices, we should have an idea of allopathic medicine.

> If ayurvedic and allopathic medicine go in parallel, it might create some conflict. If a patient visits me after taking a painkiller from an allopathic physician, I would try to understand whether, if I give ayurvedic medicine, it will cause any harm for that patient. This situation is not applicable if a patient uses only ayurvedic treatment" (AP8)

This is also the case for the patients. The most important consideration for the patients is to get good treatment for their illness. In this regard, the patients are less concerned about the division and cross practice. Nor are they concerned about the types of drugs given to them, or who prescribes them.

The professionalization of ayurveda in modern India has caused a decline of the traditional apprenticeship system. In the apprenticeship system, most of the ayurvedic practitioners came from Brahmin castes, but the majority of ayurvedic practitioners in recent times have come from non-Brahmin castes. The government of Indian has promoted a caste-neutral admissions policy in recent decades in the ayurvedic colleges to ensure the enrolment of lower-caste students. Out of a total of 60 admissions each year at the J B Roy State Ayurvedic College and Hospital, 11 places are reserved for scheduled caste (lower caste) students. The rest of the places are distributed among: general students (39), government-awarded (5), and students from Tripura State (5). However, 90% of the kabirajes surveyed, who had learned ayurveda through the apprenticeship system, came from Brahmin castes. On the other hand, of modern ayurvedic practitioners who had not had any experience of apprenticeship, only 25% of those surveyed came from Brahmin families. This change has also brought a discrepancy between the view of traditional *kabirajes* and modern practitioners in their perceptions of ayurveda. For example, of the *kabirajes* surveyed, 70% regarded quack practitioners as an important part of the health system,

as they provide health care in the rural areas. However, 75% of the modern physicians were in favour of eliminating quack practices. Many young physicians were afraid that quack practices would spoil their reputations as physicians and create negative impression about ayurveda. Young physicians were also concerned about the declining number of patients, as quack practitioners could take a share.

Conclusion

Today the training and research of ayurvedic education has moved out of the traditional apprenticeship system and into the formal education system. More specifically, students are able to study ayurvedic education at a tertiary level and are awarded formal degree qualifications for their training. This formalization and professionalization of ayurvedic education has led to a revival of interest at various points. There has been a popularization of interest in obtaining ayurvedic qualification by college-going students. At the same time, it has also revitalized and consolidated the existing identities of ayurvedic physicians as alternative yet effective doctors in the treatment of diseases. As Bengal and the rest of India are rapidly modernizing and undergoing social transformations, this revival is also being fuelled by the heightened interest displayed by the emerging middle classes.

At the same time, the professionalization of ayurveda and the formal training program have created an avenue for ayurvedic graduates to do back-door allopathic practice because of nature of their education curriculum. Most students come to study ayurveda after having failed to enrol in colleges of Western medicine.

Chapter Six

Commodification and local reach of ayurvedic products

Introduction

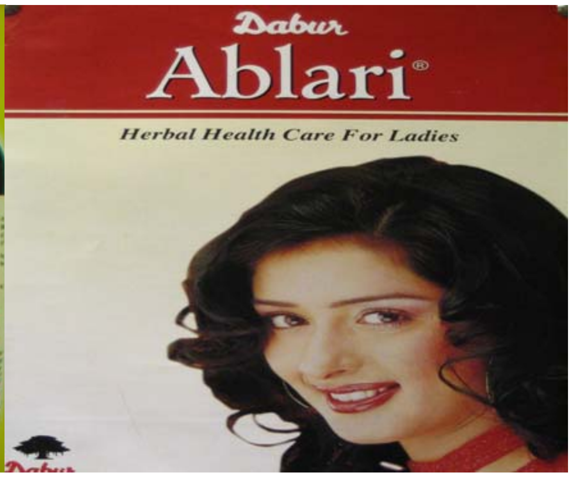
As India moves into the 21st century, it is rapidly modernising and transforming, socially and economically, and is now going onto the global stage in a rapid and intense globalization process. India has become both a producer and consumer of all kinds of products, from high technology to health products. In recent years, there have been intense debates on whether ayurvedic treatment and its related products should be regarded as a service or a commodity for public consumption. This chapter will explore how ayurvedic medicine has shifted from a home-based type of medicine to become a health commodity for local and global consumption. The patients and the general public become the consumers. The chapter will also explore how large pharmaceutical companies have appreciated ayurveda and have commodified it for profit maximization. In this process of commodification, these big companies redefine the nature of ayurvedic drugs and drug production. At the same time, this chapter will also explore how women and the body are expropriated to enhance the commodification process.

Ayurveda as a health commodity

The commodification of ayurvedic drugs and health products started in India when the large ayurvedic drug manufacturers started to link commercially-prepared

ayurveda to, and as a symbol of, Indian civilization, with a revivalist inspiration (Nichter and Nichter, 1996:292). With this process, drug manufactures have promoted traditional ayurvedic drugs with a modern sophisticated outlook (Nichter and Nichter, 1996). Over the last few decades there has been a significant rise in the number of ayurvedic or herbal companies manufacturing and marketing both classical ayurvedic medicines and patent ayurvedic medicine, or health products for mass consumption. Medical representatives of large ayurvedic companies have engaged in aggressive marketing campaigning, as medical representatives from allopathic drug companies have. In many instances medical representatives of ayurvedic drug manufacturers offer attractive benefits to ayurvedic and allopathic medical practitioners if they prescribe drugs from their companies (Nichter and Nichter, 1996:292-93), visiting allopathic physicians door to door with comprehensive 'package incentives' and insisting they prescribe their drugs or health products. In a 2001 study Bode too found that large producers of indigenous medicines in India "offer financial incentives to encourage retailers and chemists to raise the sales of their products". About 80% to 90% of ayurvedic and unani pharmaceutical products, such as patent medicines, health products, beauty products, food additives, etc., are sold directly to consumers by retailers such as ayurvedic and unani shops, chemists, small grocers, medical representatives, supermarkets and beauty parlours (Bode, 2001: 185-186). There is no clear regulation governing the sale of ayurvedic health products.





P 6.1 Dabur flyer　　　　**P 6.2** Dabur flyer

Source: Photos were taken by the author of flyers of Dabur India Limited.

Dabur India Ltd: One of the largest ayurvedic drug/health product manufacturers

Established in the year 1884 by Dr. S. K. Burman in Calcutta as a small pharmacy to produce and distribute ayurvedic medicine, "Dabur Indian Limited is the fourth largest FMCG Company in India" today, with INR 2233.72 crore (US$ 546.12 million) in yearly turnover. Dr. Burman founded Dabur in Bengal when Bengal was a single province of British India. His intention was focused on providing affordable and effective treatment for the masses at a minimal coast, as cures for various epidemic diseases of the time such as cholera, malaria, plague, etc. Because of the growing popularity and enormous success of his company in the ayurvedic field Dr. Burman expanded the commercial uses of Dabur by establishing a manufacturing plant for large scale production. In 1936, Dabur became a full-fledged company and renamed it 'Dabur India (DR. S K Burman) Pvt. Limited. Later it was shifted from

Calcutta to Delhi, in 1972. Dabur became a public limited company in 1986 and was renamed Dabur India Limited. It made its first public share issue in 1994 (Dabur India web page). A significant number of members of the company's board of directors, including the Chairman and Vice-Chairman, came from the Burman family, although they handed over the management to professionals in 1998 and hired a CEO. Recently the company has set up subsidiary group companies across the world, including Dabur Foods, Dabur Nepal, Dabur Egypt, Dabur Oncology, Dabur Pharma, etc. (Dabur India web page).

Today, the Dabur group has 8 manufacturing plants producing a range of 450 products. The rage of Dabur ayurvedic medicine and health products includes "health and beauty care products, foods and food additives, toiletries, bulk drugs, pharmaceuticals, diet supplements, natural gums, and animal health products" with some popular brand, such as Dabur Amla, Dabur Vatika, Dabur Chyawanprash, etc. (Dabur Therapeutic Index, 2004: ii). In 2004 the company had, nation-wide, over 5000 distributors covering both urban and rural India. Dabur products for health care, skin care, oral care, hair care, foods, etc., are also being exported overseas and are available in more than 50 countries, particularly in the Middle East, South-East Asia, Africa, the European Union and America. Apart from its various other products, Dabur also produces classical (*Shastriya*) ayurvedic preparations and the number of such medicine is more than 350 (Dabur Therapeutic Index, 2004: ii).

The corporate office of Dabur India Limited is located in Ghaziabad and its registered office is in Delhi. It has branches offices in Ahmedabad, Bangalore, Calcutta, Chandigarh, Chennai, Delhi, Guwahati, Hyderabad, Indore, Jaipur, Kochi,

Mumbai, Patna, and Raipur, and overseas offices in Dubai, Egypt, Bangladesh, Nigeria, London and Nepal. Apart from this, Dabur India Limited maintains its eight factories in various parts of India. In recent decades Dabur has introduced 'one stop counters' to provide ayurvedic treatment and medicine for customers, where free heath consultation is provided by institutionally-qualified ayurvedic practitioners, to ensure the availability and accessibility of both ayurvedic practitioners and Dabur ayurvedic medicine for patients or health consumers in the same place. There are currently 242 such counters in 17 different states of India (Dabur India web page).

Like large Western pharmaceutical companies, local ayurvedic pharmaceutical corporations have intensified their production, marketing and sale of ayurvedic medicines. In the last few decades, local large ayurvedic pharmaceutical companies such as Dabur and Baidynath have started producing drugs for all kinds for mainstream diseases and illnesses under the ayurvedic banner. In addition, they have also produced health products and supplements, beauty products and cosmetics for women. Today, Dabur produces 35 categories of ayurvedic medicines for illnesses that range from specialized drugs for diabetes and high blood pressure to non-prescription drugs for common colds, flues, headaches, etc. (Dabur Therapeutic Index, 2004). The Baidynath pharmaceutical company produces asimilar range of products. Together these two big local pharmaceutical companies have the largest local market share of the ayurvedic drug market.

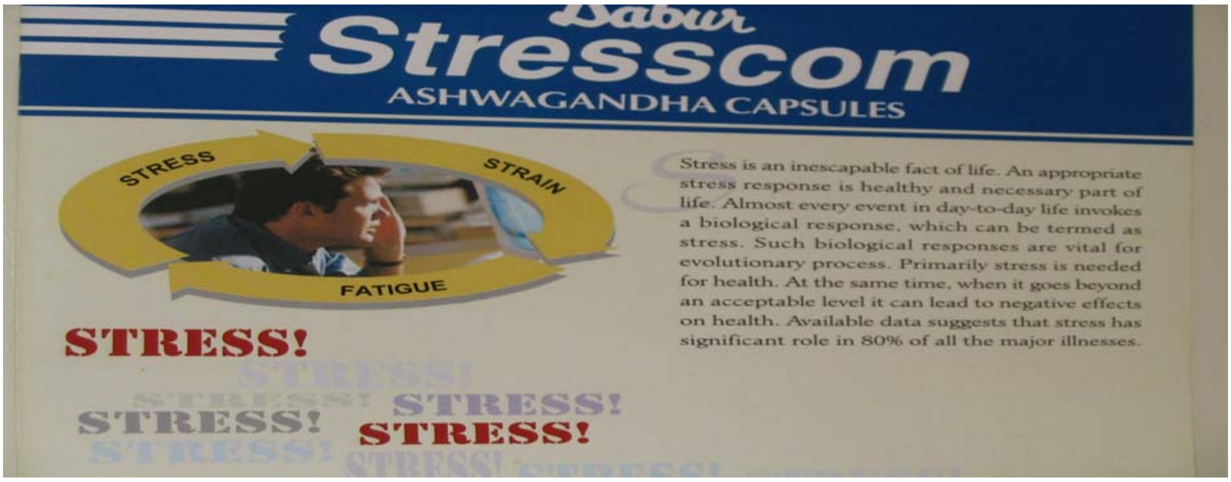
Marketing strategies

Many of these ayurvedic products are aimed at the local Indian market. In order to appeal to the middle class, the young and women, the large local pharmaceutical companies have adopted various marketing strategies. To make them

appear modern, the drugs, health supplements and beauty products are packaged in attractive modern styles, with English, Hindi and Bengali language labels. Nichter and Nichter give two reasons for the increasing popularity of English names for ayurvedic drugs and health products: firstly, "because of a general ascription of 'quality' attached to a new, modern and foreign sounding name"; and secondly, because many MBBS doctors and recent graduates from ayurvedic colleges are reluctant to prescribe ayurvedic medicines with Sanskrit names (Nichter and Nichter, 1996:294-5) - probably because of their poor knowledge of, and fluency ing, Sanskrit. Simultaneously, a large number of modern allopathic doctors, as well as young ayurvedic practitioners who wish to be seen as modern physicians, are enthusiastic to prescribe ayurvedic patent medicines and health products instead of classical (Shastriya) ayurvedic preparations. For ages, English, Hindi and Bengali names, such as Good Care, Ayu Slim, etc., have had great drawing power and with the power of advertising these health products have increasing popularity among consumers.

In addition to specialized drugs for chronic diseases and common illnesses the rise of new health and beauty products has further reinforced ayurvedic commodification. Most of the patent ayurvedic medicines and health products are new creations. For instance, Dabur produces 26 medicated oils and 4 kinds of products made from ghee (one kind of butter) while Baidynath catalogues 4 perfumed hair oils and 29 medicated hair oils. It has been widely accepted that fashion is the central linkage among production, merchandising, and consumption in capitalist societies. The capitalist transformation in ayurveda has enhanced a market sphere with a fashionable presentation of products, and thus health has turned into a commodity. Nichter and Nichter argue that large and small ayurvedic drug manufacturers produce

and market their products to address popular health concerns such as male impotence, women's reproductive health needs, mental distress, and physical lassitude (Nichter and Nichter, 1996:297).



P 6.4 Dabur flyer

Source: Photo was taken by the author.

Two categories of ayurvedic products - cosmetics and health supplements - are most popular. Within 7 days in September 2004, a total of 205 customers visited Dabur Ayurvedic Medicine Shop. The best-selling products were herbal-based cosmetics and essential oils - health tonics and capsules, male sex stimulus pills and capsules, remedies for common illnesses, remedies for stomach-related problems, headache and other pain remedies; and reproduction and skin disease-related medicines and health products were also purchased by significant numbers of

consumers. Other ayurvedic medicine shops, such as Baidynath, reported similar sale trends.[39]

In present-day India there continue to be a small group of ayurvedic *kabiraje*s who prepare their medicines for their patients, although the majority of ayurvedic practitioners now prescribe wholly commercially-produced ayurvedic drugs. Out of this small group of *kabirajes*, 25% of those surveyed doubted the effectiveness of the commercially-produced drugs. However, the unavailability of various types of herbs made it difficult for the *kabirajes* to prepare their own health remedies. Another factor contributing to the decline in this practice is also the lack of knowledge and skills among the younger-generation ayurvedic physicians. Those kabirajes who prefer home-produced medicine hold views similar to the following:

> "I prefer *shastrio* (classical) medicine because it follows classical pharmacological preparation. This is because commercially-produced drugs have many side-effects. The ayurvedic *kabirajes* not only have the skills, knowledge and patience in the production of herbal remedies. They also hold high ethical standards so that what they produce is good and effective for the ailments and has little or no side effects. Besides, ayurvedic *kabirajes* are not driven by profit maximization, unlike the big drug companies" (AK 3).

Apart from the local market, there is also the development of an international market for herbal-based drugs, health supplements and beauty products. As a result of this global demand, many Indian drug companies, such as Dabur and Baidynath, are mass producing and creating a large range of herbal-based drugs for the global market. At the state level, the Central Research Institute (Ayurveda) is a good example of

[39] Participant observation was conducted in Dabur Ayurvedic Medicine shop selling ayurvedic medicine and products from 18 September to 24 September, 2004.

state research for ayurvedic medicines. The drug manufacturing and research unit of the CRI researches and uses modern sophisticated technology to produce ayurvedic drugs based on ancient formulas. Chemists and pharmacologistawith PhD degrees are employed by both the Central Research Institute (Ayurveda) and Dabur India's research division to research and undertake laboratory experiments for new drug formulas.



P 6.5-6.6 Central Research Institute (Ayurveda) uses this modern technological equipment in their pharmacy and drug manufacturing unit.

Source: Photos were taken by the author during participant observation in the CRI.

Such mass production of ayurvedic drugs and products for global and local markets sometimes do not find support among the more traditionally-minded *kabirajes*. One *kabiraj* commented that:

> **"**Medicine should be prepared at a particular time of the day when the components of the medicine (mercury for instance - a major component to make ayurvedic medicine) are very active. I prepare medicine immediately after I finish my prayer to God (Ram) early in the

morning. At that time, I have better concentration and am spiritually motivated. It is recognized in the ancient ayurvedic text that a *kabiraj* should invest full concentration during medicinal preparation. He/she should consider time, weather, environment, and season (*shamoy, thithi*) when collecting plants and herbs from the garden. At different times of the day or night, plants have different qualities. Also, the environment also influences the quality. For instance, if the plants grow near the public toilet, the soil condition has impact on the chemical formation and organic compound of the herb. Modern technology does not consider these aspects before manufacture drugs". (AK 9)

The traditional *kabirajes* surveyed are lessdependant on commercially-manufactured ayurvedic drugs and health products produced with the help of modern technology and laboratory equipment. In addition to arguing that modern technology and large production do not consider the environmental condition of plants and herbs during collection and in preparing medicine, they worried that drugs manufactured commercially with the help of modern technology ignore the condition of the individual patient a consideration which is one of the fundamental principles in ayurveda.

New consumers and emerging demands

During a rainy summer afternoon in August 2005, I was interviewing a *kabiraj* from a traditional ayurvedic family in Bengal. He was dressed in an impressive *dhuti and panjabi* (*kabiraji* custom) and offered me a cup of tea with some sweets, a typical custom in Bengali households when entertaining visitors. He appreciated my research only because I am a Bengali and working on ayurveda in the international arena. According to him, nationalist glory is very much alive in ayurveda, especially

‘Bengaliness’[40], while the division of Bengal has caused ayurvedic decline. We were chatting about the recent trend of ayurvedic naturalization and the emerging rise of natural health products. Suddenly he started shouting: “all these are devilry acts….devilry acts” - “There are some scoundrels doing business with ayurveda….they are destroying ayurveda”, he added. He still perceived ayurveda as an ancient Indian medical tradition which was subjugated and destroyed by the foreign rule and should be revived in its ‘classical’ form.

Bode noted that, at the end of the twentieth century, the turnover of the Indian indigenous drug industry was much larger than the government funding of ayurvedic and unani education, treatment and research. Across India, around 8,000 licensed pharmacies were producing and manufacturing a wide range of ayurvedic and unani medicine, health products, and supplements (Bode, 2001:184). One of the foremost indicators of the rise of ayurvedic demand is the huge sales volume recorded by different companies. New companies are investing in the industry and, as mentioned, many new drugs/health products are available on the market. The number of patients attending ayurvedic health clinics has also risen significantly. Statistics from the Calcutta-based Central Research Institute (Ayurveda) show that the numbers of patients attending the out-patient department rose significantly over ten years. The total number of new[41] male patients in 2003-04 was nearly three times higher than it was in 1994-95, while the number of new female patients was two times higher in the

[40] Bengal was ruled according to the presidency until the early twentieth century under the British colonial administration. After that it was divided into West Bengal and East Bengal. At Indian independence West Bengal joined with India and East Bengal with Pakistan, according to their religious majorities. East Pakistan became Bangladesh, an independent country, in 1971 after 9-month liberation war.

[41] Patients who are visiting for the first time for this particular disease.

same period. The figures for both male and female repeat-visit[42] patients in the same period also increased considerably, from 4,406 adult males in 1994-95 to 6,812 males in 2003-04, and from 5,401 adult females in 1994-95 to 5,944 in 2003-04, respectively.

Table 6.1

Number of patients at OPD from 1994-2004 in the Central Research Institute (Ayurveda)

Year	New Patients				Patients making repeat visits			
	Adult		Child		Adult		Child	
	Male	Female	Male	Female	Male	Female	Male	Female
1994-95	1,387	1,513	114	128	4,406	5,401	238	273
1995-96	1,489	1,777	149	150	4,614	6,365	304	238
1996-97	1,464	1,631	108	128	4,656	5,781	290	242
1997-98	2,740	2,292	273	282	5,673	6,023	402	398
1998-99	2,760	2,549	251	251	5,595	6,292	329	385
1999-00	3,072	2,520	251	253	6,608	6,336	377	362
2000-01	3,905	2,943	317	270	7,420	6,564	431	308

[42] Patients who made at least one repeat visit for the same disease

2001-02	3,874	2,963	260	187	7,693	7,356	353	293
2002-03	3,793	2,727	174	187	6,980	5,797	279	224
2003-04	4,208	3,127	243	201	6,812	5,944	267	228
Total	28,692	24,042	2,136	2,037	60,457	61,859	3,270	2,951

Source: Central Research Institute (Ayurveda), Bidhannagar, Kolkata, C.C.R.A.S., Deptt. Of AYUS, Ministry of Health and Family Welfare, Government of India, Annul Progress Report 2003-2004:70)

These overall increases were also observed during the fieldwork, in that 90% of patients felt that the demand for ayurvedic treatment had risen significantly. A new consumer class has already emerged; with a large majority of consumers are purchasing and using ayurvedic health products and supplements.

Drug standardization


The Telegraph

Taste of true life
We the people — the real heroes of the reel world
ETC Cover Story

In Pitt's shoes
Poverty-fighter Jolie heads to Africa, MTV follows
FOREIGN Page 3

CALCUTTA FRIDAY 19 AUGUST 2005 Rs 2.00 CE www.telegraphindia.com

British cloud on ayurvedic drugs

OUR BUREAU

found that several herbal products in the Canadian market contained high levels of the metals.

The products listed are all made by Indian companies, like Dabur, Zandu Pharmaceuticals, Himalaya Drug Company and Hamdard, whose Pakistani counterpart has also been named.

Roy Alder, the agency's director of executive support, said: "Medicinal products containing high levels of heavy metals pose a serious public health risk. Many of the products we suspect to have entered the UK may contain mercury, arsenic and lead. These metals can cause severe nausea, vomiting and abdominal pain. Other serious problems such as kidney damage, convulsions and coma have also been reported."

Several studies in recent years have found heavy metals in ayurvedic medicines imported from India. In some cases they may be contaminants, but in others they are deliberately included in the belief that they have health benefits, the paper said.

CAUTION LIST
The suspect medicines and the companies producing them:
- Karela tablets, Shrji Herbal Products
- Karela capsules, Himalaya Drug Co, India, & Charantia, UK
- Yograj Guggul tablets, Zandu Pharmaceuticals
- Sudarshan tablets, Zandu Pharmaceuticals
- Shilajit capsules, Dabur India Ltd
- SAFI Liquid, Hamdard WAKF Pakistan & Hamdard WAKF India
- Maha Sudarshan Churna Powder, Zandu Pharmaceuticals, D&K Pharmacy and Dabur India Ltd

Indian drug firms said they have had the drugs tested by foreign agencies. S.K. Mitra, executive director of research and technical of Himalaya, said: "We have had *karela* capsules tested by Rigaku, a research laboratory in Texas and by the Indian Institute of Technology, Chennai. Both have given a clean chit."

Its *karela* capsules, said to promote vitality and control blood sugar, are on the list the UK regulator has asked consumers to stay away from. Claimed to be a rejuvenator, Shilajit, sold by Dabur, is also on the list.

A Dabur spokesperson said: "We are very sensitive to issues related to our products. We have got our Shilajit tested by SGS (based in Switzerland), a global chain of independent and renowned testing laboratories, that confirms that our product does not contain heavy metals."

In India, the market is brimming with myriad herbal drugs, without any standardisation or quality control. These drugs have not undergone rigorous pharmaceutical studies and clinical trials.

Under Indian laws, a company can produce and sell a cocktail of herbal extracts as long as each ingredient is mentioned by name in one of several ancient ayurvedic texts.

"There are now signs that

Delhi dares to look at

P 6.7 A newspaper report about ayurveda

Source: Photo was taken by the author of the *The Telegraph*, Calcutta, Friday 19 August 2005.

Drug standardization is one of the major challenges ayurveda encounters today. Many new companies have launched their businesses in recent decades and manufacture patent drugs without quality control of pharmaco-dynamics. As ayurvedic products became popular in both the local and international arenas, these products are subjected to closer scrutiny and regulation, especially from regulatory agencies overseas. In August 2005, a newspaper report, entitled ***'British cloud on ayurvedic drugs',***[43] concerned the poor quality of ayurvedic drugs produced in India.

> *"Indian ayurvedic products sold in Britain have come under the scanner after the drug regulatory authority there issued a warning about the possibility of dangerous levels of heavy metals in the herbal remedies. The medicine and health care regulatory agency said these products might have entered the British market and advised consumers not to take them, according to The Times, London. Its warning came after a similar one issued by its counter part, Health Canada, which found that several herbal products in the Canadian market contained high levels of the metals. The products listed are all made by Indian companies, like Dabur, Zandu Pharmaceuticals, Himalaya Drug Company and Hamdard, whose Pakistani counterpart has also been named.*
>
> *Roy Alder, the agency's director of executive support, said: "Medical products containing high levels of heavy metals pose a serious public health risk. Many of the products we suspect to have entered the UK may contain mercury, arsenic and lead. These metals can cause severe nausea, vomiting and abdominal pain. Other serious problems such as kidney damage, convulsions and coma have also been reported."*

[43] *The Telegraph*, Calcutta, Friday 19 August 2005.

Several studies in recent years have found heavy metals in ayurvedic medicines imported from India.

There are now signs that the government is responding to calls by doctors and drug control directorate officials for a change of rules to regulate manufacture and sale of ayurvedic products. Ashwani Kumar, the drug controller of India, said over phone from Delhi: "There is nothing secret about the fact that ayurvedic drugs have some permissible levels of metals known as bhasma used for centuries. No one has ever questioned its compositions or quality, but with controversies surrounding its efficacy emerging in the US, Canada and other countries, the government is now seriously looking into the issue."

The National Policy on Indian Systems of Medicine & Homoeopathy 2002 also recognized the fact of poor quality control in their policy report. The report stated that although " drugs manufacture and related matters are covered under Drugs & Cosmetics Act, 1940 and Drugs & Cosmetics Rules, 1945, the safely, efficacy, quality of drugs and their rational use have not been assured" (National Policy on Indian Systems of Medicine & Homeopathy 2002, Article 5.1). The report further stated that although there were several enforcements mechanisms advised in the Act, they still remain ineffective because of poor implementation of the enforcement laws. There was still reluctance among a large number of ayurvedic drugs manufacturers in various parts of India to maintain standard manufacturing practices and ensure the quality of their medicine or health products (National Policy on Indian Systems of Medicine & Homoeopathy 2002, Article 5.1).

Of those surveyed, 89% of the patients had no ideas about drug standardization. They depended on faith in the function and effectiveness of the ayurvedic drugs they used. Many ayurvedic physicians were also frustrated at the poor quality control of ayurvedic drugs.

Women as consumers

This section examines how ayurveda has become commodified, especially as beauty and sexual products. It explores how woman was represented in the ayurvedic texts as primarily a medicalized body, as well as the transformation of this female medicalized body into a natural female body in the contemporary Indian context. Here, the large ayurvedic pharmaceutical companies are instrumental in redefining the female body in order to establish a market niche for health and cosmetic products. The ideal female body and appearance is correlated to the consumption of ayurvedic products. Likewise, the pharmaceutical companies also seek to redefine Indian manhood with reference to sexual powers, which are again correlated to ayurvedic product consumption.

Female representation in ayurvedic texts

In, 'Is female to male as Nature is to culture?', Ortner perceives the biological differences between men and women as a basis of sexual asymmetry grounded in cultural symbols and ideologies. She sees women everywhere associated with nature, and that this has grounded the subordination of women because of the fact that every culture devalues nature, as 'culture' is seen as superior to the 'natural' world, and attempts to control and transcend nature. Thus, culture/men "controlled and contained" nature/women and ensure its/their superiority (Ortner, 1974:71). This

question concerns whether this nature/culture distinction can describe human medical and health issues. Ortner also gives physiological explanations to elaborate her argument. Under the heading 'Why is woman seen as closer to nature?' Ortner discusses three levels of physiological facts that ground women's close connection to nature. These are:

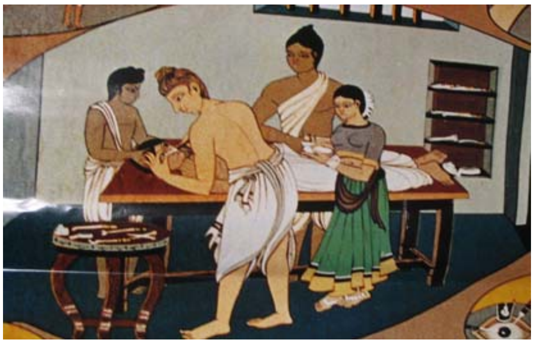
> "1) *woman's body and its functions,* seem to place her close to nature, in contrast to man's physiology, which frees him more completely to take up the projects of culture; 2) woman's body and its functions place her in *social roles* that in turn are considered to be at a lower order of the cultural process that man's; and 3) woman's traditional social roles, imposed because of her body and its functions, in turn give her a different *psychic structure*, which, like her physiological nature and her social roles, is seen as being closer to nature" (Ortner, 1974:73-74)

For Ortner, men are associated directly with culture as opposed to nature, and culture holds more creative power. By contrast, woman creates "naturally from within her own being", that is, she can raise a child in her own body. Apart from this biological role, women's social roles are also seen as closer to nature in many societies because of women's involvement in certain social functions such as child caring and breast feeding (Ortner, 1974:77).

In this regard, Ortner's model is applicable to our understanding of gender representations in the *Charok* and *Susrut Samhita* ayurvedic texts. In spite of the presence of numerous goddesses in Indian myth, such as Devi Durga as supreme goddess, Devi Sharoshoti as representing knowledge and education and Devi Laxmi as the deity for wealth and prosperity, there is no mention of a goddess of medicine. Likewise, there was no mention of women as ayurvedic practitioners in ancient texts. Zimmer and Dunn asserted that the Indian practitioners of ancient ayurveda were

indeed male (Zimmer, 1948:76; Dunn, 1976) and the admission of females into ayurvedic practice was limited until recent times. Classical ayurvedic texts mention ayurvedic treatments as contributing to the health of kings and court leaders, soldiers, and male members of upper castes (Dunn, 1976). The texts also mention that *Ashwinikumars* (divine physicians) provided an artificial leg to Queen Vispala by surgical procedures, and that women were featured in ayurveda only as patients. Ayurveda was thus stagnantly male-dominated.

However, in fact, women played secondary roles as nurses to assist the physicians or as aides in preparing medicines. It is apparent that Nagarjuna, an alchemist of ancient India, employed women to assist in medicinal preparations (AYUSH Yearly Calendar, 2004). Susrut (author of *Susrut Samhita*), the father of surgery, who performed plastic surgery on ears, also employed women as helpers - during surgical performances whereas men acted as junior physicians (AYUSH Yearly Calendar, 2004).[44]





P 6.8 Performing cataract surgery according to Susruta's technique

P 6.9 Sushruta (1000 BC), Father of Surgery, performing plastic surgery on an ear

Source: AYUSH Yearly Calendar 2004

[44] Some photos from AYUSH yearly calendar 2004 showed that both Nagarjuna and Susrut are assisted by women during their medical experiments. This calendar was published by the Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy, Ministry of Health and Family Welfare, Government of India

In the *Charok Samhita*, especially *sharir sthan*, women are associated with the qualities of breastfeeding, delivery, pregnancy and menstruation, etc. – thus consigning them to Ortner's category of belonging to nature. Here, the text considers as having "incomparable group physiology" (*otul gotrio sharir*), and explores womanly functions such as pregnancy, safe birth delivery, female fertility, birth and information on infants, foetus, twins, premature births, etc. The text also provides details on 'gynaecological physiology' and 'physiology for ideal pregnancy' and describes causes of pregnancy, growth of pregnancy, sages' views about the growth of pregnancy, background of pregnancy, foetus condition during first, second and third months, sex identification of the foetus, pains and pleasures of pregnancy, moods and emotions of pregnant women, foetal development, time determination for delivery, and causes of infertility (*Charok*, *sharir sthan*). Ortner's analysis is very much relevant here, as she also refers to women's confinement within the domestic domain, and within the domestic family in particular, where women are primarily associated with the rearing of children.

The *Charok Samhita* text (*sutro sthan*) also elaborated on "women problems" such as menstruation and ideal time for sexual intercourse to enhance pregnancy, and prescribed treatment for such women's problems. This is contrasted with the male representation in the text as a Brahmin. Those Brahmins who learned the Vedas and attained knowledge of medicine and treatment became *vaidyas* (*Charok*, *chikitsha sthan*, chapter 1, paragraph 1). The attainment of the *vaidya* status belonged solely to the men's sphere, and women were barred from attaining it. Women were thus represented as inferior to men, and were to serve men. In this sense, the text outlined

male superiority and power: “noble-spirited man with virtue, wealth, fame and affection fairly wishes to exercise magical supremacy, while beloved woman is the best sphere to exercise mystical power. Beauty, smell, touch, fluid and flavour - all the five senses of the organs are highly appreciated by man, which he obtains together from woman’s body. There is no confusion that women are the more affectionate” (*Charok, chikitsha sthan*, chapter 2, paragraph 3). “A pretty, youthful, glorious, obedient, well-formed, and well-educated wife having all good qualities is best for exercising man’s miraculous power” (*Charok*, *chikitsha sthan*, chapter 2, paragraph 1). Man is also described as the symbol of the child’s inheritance: “the man with many sons/children is complimented in the universe as a bearer of good, benevolence, success, power, widen”, while no compliment is given to women for their child-rearing (*Charok, Chikitsha sthan*, chapter 2, paragraph 3). All these representations ensure very minimal entry of women into the ayurvedic profession. Ayurveda as a medical system thus considered women primarily as patients, and woman as a medicalized body.

The *Sharir sthan* (human anatomy and physiology) part of the classical ayurvedic text *Ashtangahridaya* also contains chapters on women-related issues, such as chapters one and two, which describe gynaecology; paediatrics, and especially reproduction: pregnancy; sex determination; purity and pollution of sperm; menstruation; foetus condition during different phases of pregnancy; pre-natal, ante-natal and post-natal situations; labour pains; and related diseases and their treatments are all discussed.

Female body as “natural body”

The perception of the human body as a ‘medical body’ and/or ‘natural body’ is one of the key themes for understanding the definition and causation of diseases and illnesses within the ayurvedic framework. In modern capitalist Indian society, the big ayurvedic pharmaceutical companies have attempted to redefine the female body - from a medicalized to a natural body. In so doing, these ayurvedic companies subjugate the ayurvedic ideology to the capitalist ethos, as they have, in recent years, constructed the female ‘natural body’ as a market strategy to promote their health and beauty products. Michel Foucault delineated a historical cohesion of medical perception, bio-medic consideration of the human body and the existence of disease and illness in the specific space of the body. Foucault stated that, in the late eighteen or early nineteenth century, the bio-medical epistemology normalized the idea of the human body as the prime space to locate disease. According to Foucault, the practice of configuration of a disease in a specific location or space of the human body was superimposed in nineteenth century medical practice. Foucault considered the human body as an ‘anatomical atlas’ which is constituted by the ‘medico-scientific gaze’ (Lupton, 1994). According to Foucault, medicine started to function as an institution to exercise disciplinary power on the human body in the late eighteenth century (Foucault, 1975). In this sense, disciplining the female body and transforming it from a medical into a natural body has become the goal of the big ayurvedic corporations in their effort to market their products on local and global markets.

Langford argues that bio-medical science and ayurveda did not perceive the human body in a similar manner. For instance, if biomedical science understands the human body, person and illness as object, the ayurvedic outlook understands body,

person, and illness as processes and patterns of relationships. She further notes that biomedical practitioners generally configure human disease or illness “as a discrete entity”. By contrast, ayurvedic practitioners mostly constitute human disease or illness “as a disruption in delicate somatic, climatic, and social systems balance” (Langford, 2002:11). Ayurveda configures human disease and illness as the outcome of the natural environment and socio-cultural surroundings, as the human body is inseparable from the natural setting a person lives in.

Despite the fact that the ayurvedic medical system has a specific approach to perceive the human body the recent naturalization of ayurvedic health products by the large pharmaceutical companies contradicts the ayurvedic medical principle. Especially, the massive rise of female body-oriented ayurvedic natural products in modern Indian society does not stand as a medical concern. Although the biggest pharmaceutical companies repeatedly propagate their body-related natural products as having health concerns, targeting women consumers, this simply fosters another ambiguity about the female body as “natural body”.

Media representation of the body

As the big ayurvedic pharmaceutical companies turn their attention to the development of beauty products for women, ayurveda has been propagated as a natural healing system, and ayurvedic medicine/health products are featured as natural remedies. Advertisements, both in print and in the electronic media, have been broadcasted repeatedly concerning ayurvedic beauty products that are essential for ‘beauty and natural care’ for the body. In an era of commodification, these advertisements can be divided into two categories: namely beauty and related

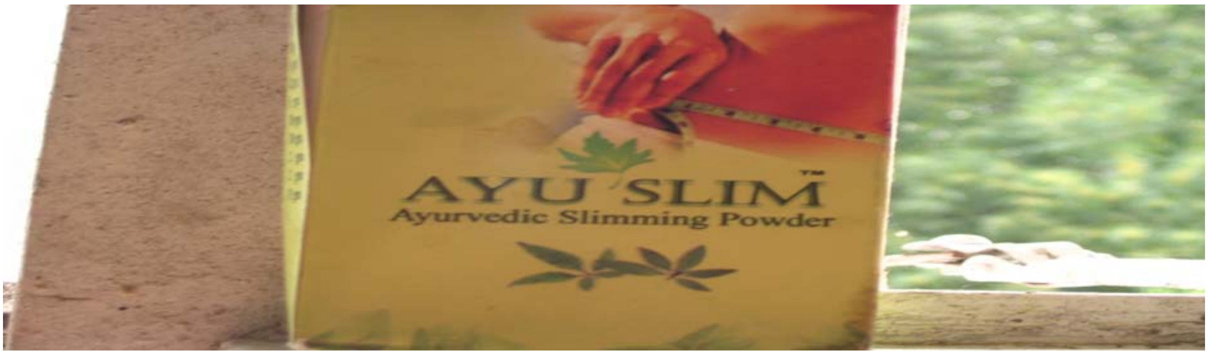
products, and ayurvedic medicines. Beauty products redefine beautification and youthful rejuvenation, while patent medicines redefine healthy lifestyle. The power of the media has created a new taste and a new trend of consumption behaviour through the heart-rending fashions of product presentations. This has inspired women to consume natural/herbal 'beauty and health' products, and ayurveda has become the selected choice to maintain the natural beauty of the body. Below is a case study of how ayurvedic beauty products are marketed through mass advertisement.

WWS[45] has marketed four health products as ayurvedic-based products and has advertised them for about 15-45 minutes on several television channels. The products are: Ayu Slim (ayurvedic slimming powder), D Care Plus (for diabetes), Danpury (ayurvedic tooth powder) and Rup Amret (ayurvedic fairness cream). WWS has an expanded advertisement programme. In Bengali, *dat*' means tooth and Puri is a holly city, while Danpuri is used as a toothpowder name. Similarly, *rup* means fairness and *amret* means magical honey, so that and Rup Amret means a magical honey for fairness. The glamour of these products is reinforced by commissioning actors and actresses to appear in the advertisements. The slimming and diabetes products are priced expensively, in the Indian context, and only affluent people can afford to purchase them. The drug company offered a 100% money back guarantee if their products did not work. They provided online shopping facilities, toll free phone call service for any inquiry, and retail sale from their office or distribution units.

One of the common themes of all the four advertisement is to increase physical attraction and promote a sense that obesity, bad teeth, lack of fair

[45] WWS provides online shopping for ayurvedic health and beauty products

complexion and diabetes cause the loss of physical attraction of a spouse, boyfriend/girlfriend, colleague, boss, subordinate or friend. However, the situation reverses dramatically after the use of these health products. One of the key advertising targets for these ayurvedic drug companies are women and their bodies and beauty. Beauty products that focus on producing the perfect body shape - i.e. a slim body and youthful and blemishless fair face and skin - target Indian women through intense advertising in print and electronic media.



P 6.10 An ayurvedic slimming product

Source: Photo was taken by the author from an Ayu slim folder, WWS Company, India

For example, the WWS Company spent large sums of money on advertisements broadcast on several satellite television channels that focus on selling slimming products. One of the selling and advertising strategies was to promote the idea that ayurvedic products do not have side-effects. Thus, one of the advertisements for a slimming product states that "indigenous technology, natural procedure and no side effect is the key features of Ayuslim. This product is made using 52 types of roots and plants. It saves time, reduces weight, builds muscle and creates perfect look"

(Ayuslim television advertisement, 2004).[46] The advertisement also portrays women as satisfied customers who have benefited from the product, and men as approving such products for their wives or girlfriends.

Selby explains the ways ayurvedic ideas have been used in Europe and America for the development of women's health-related cosmetics industries. She notes that, because of the booming cosmetic industries and various beauty-related products, women's health concern has been largely replaced by beauty concern, and ayurvedic brands have been used as a "lucrative market strategy" (Selby, 2005:121). She gives the example of American super model Christy Turlington, who used ayurvedic cosmetics branded Sundari (Selby, 2005:127-28). *Sundari* is a Sanskrit word commonly used to describe a fair lady in Indian society. According to Selby, Turlington explains in her webpage that "in Sanskrit, Sundari translates as 'beautiful women'. Today, it also represents a system of natural ayurvedic skin care suited to meet the needs contemporary women face in developing their individual inner and outer expressions of beauty" (Selby, 2005:128). Selby concludes that the Sanskrit knowledge system has been transmitted among Europe and American health consumers during the post-modern era. For instance, ayurvedic knowledge has been used to create new body images for wellness and beauty (Selby, 2005:129). In participant observation conducted during September 2004 in an ayurvedic medicine shop, out of a total 134 customers observed, 'oil and cosmetics' was the best-selling category, purchased by 33 customers. 120 customers were male and only 14 were female. 51 male customers purchased health products for their wives, children or

[46] This advertisement was broadcasted on the Bangla television channel 'Alfa TV Bangla'.

other female relatives. The best-selling cosmetic products were hair oil, hair tonic, hair massage and facial cream.

Bode noted that consumerism in modern Indian society is increasing, especially since 1990s, because of massive growth of advertisements for ayurvedic health and pharmaceutical products promoted by the drug manufacturers (Bode, 2001: 186). Ayurvedic cosmetics and beauty products advertisements are found on highway billboards, in various beauty competitions or fashion shows, on the roadsides in city, in city centres, in small ayurvedic shops, in super markets, and even at international scientific conferences where scholars of ayurveda are participating (Bode, 2001). Popular and widely-selling magazines in West Bengal such as *Anand Bazar, Anand Mela and Desh Patrika* carry such advertisements. The advertisements carry a range of herbal or ayurvedic products and beauty cosmetic products such as facial creams, essentials oils, hair products to toiletries and slimming products. They also featured sexual impotence products for men.

How do the consumers of ayurveda and health service providers perceive this new commodification strategy? Of the 30 surveyed, 70% of the ayurvedic practitioners felt that drug companies had misled Indian women by redefining body and beauty. They have influenced the perception of body and beauty as synonymous with the consumption of ayurvedic beauty and health supplement products. In this sense, women purchase cosmetics products not for medical needs but for beauty and health concerns because of their growing fascination towards what are considered the ideals of body and beauty such as fairness, slimmness, etc. Today there is also another

perception, which equates ‘herbal’ with ayurveda, and people often misunderstand herbal products as ayurvedic products. According to one practitioner:

> “The cosmetic issue is different from the medical issue. The present initiative is to revive ayurveda by promoting natural products. Peoples used extensively alkaloid cosmetics before and became frustrated with severe side effects. Promoting ayurvedic natural products will help popularize ayurveda, which is good. However, ayurveda is considered in the Western world as ‘holistic medicine’. Overemphasizing the cosmetic and beauty part will lead to the misunderstanding that ayurveda is concerned with beauty and fairness rather than with serious health issues” (AP 1).

Of those patients surveyed, 60% of the male and 65% of the female patients noted women’s affection for ayurvedic cosmetic products. One female respondent commented:

> “There is no side effect in ayurved. I used the cosmetics products such as Ayur Beauty Care, Ayur moisturiser, Ayur Vaseline, Ayur facial, lip gel, etc., as there is no chemical component used in these products. Although Ayur cosmetics are costly, they are very effective and keep my skin shiny, fresh and smooth. The skin usually becomes dull during middle age, black spots come under the eyes, and Ayur new products remove the spots from the eyes. Many old women look younger after they use Ayur products” (FPP15).





P 6.11-6.12 Ayurvedic product advertisements

Source: Photo 6.11 was published in *Ananda Bazar* magazine, puga (biggest religious occasion for the Hindu community in Bengal) 1411 issue; photo 6.12 was taken by the author during participant observation in an ayurvedic shop in September 2004.

Ayurveda perceives the human body for medical reasons and proceeds with the treatment of diseases and illnesses. By contrast, with global commodification, the human body, especially the female body, comes to be seen as part of the 'beauty and health' industry, where beauty becomes an essential part of healthy life and can be affected by ayurvedic treatment. Ayurvedic products have thus been promoted as essential elements contributing towards the maintenance of beauty and health of the human, and especially the female, body.

'Ayurvedic magic bullet'

Not only beauty and natural health care but also sexual power boosters have become pre-eminent features of contemporary ayurvedic market strategies. In mainstream medical literature, sex is widely recognized as a "fundamental body process" parallel to others such as "respiration or digestion" (Kolodny, 1987:5). From medical and psychiatric perspectives, certain types of difficulties in sexual

functioning are considered abnormal, especially of men. Men who "are unable to obtain or maintain erections in a substantial portion of sexual opportunities are seen as sexually dysfunctional, as men who are unable to ejaculate intravaginally" (Kolodny, 1987:7). In ayurvedic remedial practice, *vajikarana* (virilisation) has been regarded as one of the eight branches of ayurveda. *Vajikarana* can analyse the increase of sperm count for men; purify 'polluted' sperm; enable sexual ejaculation, competence and sperm reproduction; and enhance the strength of men (*Susrut, sutro sthan,* chapter 1, and paragraph 11). Charok also described the causes of sexual weakness for men in intercourse with their wives, especially, the problems of elderly men, and provided potential medical remedies to recover sexual power (*Charok*, *chikitsha sthan*, chapter two, paragraphs 4- 6).

Charok Samhita states that "a man should have intercourse with his wife after taking certain beverages containing food value and properties of honey that create heat, vitality, and that increase body temperature to enhance power. Men should be excited and concentrate on sex during intercourse. After finish intercourse with his wife, a man should take a bath and drink milk with meat before he goes to bed. He will be stimulated again for intercourse if he follows this routine" (*Charok, chikitsha sthan*, chapter 2, paragraph 2-8). Another paragraph from Charok informs those who aspire to longevity that they should avoid sexual intercourse before the 16th and after the 70th year of age (*Charok, chikitsha sthan*, chapter 2, paragraph 2-8). The ayurvedic text also mentions the effects of stress and anxiety as "fear, suspicion, distrust, wet dreams, immature ejaculation, loss of sexual desire for wife, suspicion about wife's sexual life, affliction, etc., cause loss of sexual power and ability for men, while mental stability and excitement is a prerequisite for sexual power" (*Charok,*

chikitsha sthan, chapter 2, paragraph 2-8). The *Susrut Samhita* also prescribes the procedure of preparing and manufacturing remedies for male sexual enhancement in the *Khinbolio Bajikaron* (weak virilisation) chapter. It notes that "sesame, enamel, winter rice, etc. should be mixed with sugarcane drink and cooked with pig fat. The mixture then should be cooked with ghee and eaten before sexual intercourse" (*Susrut*, *chikitsha sthan*, chapter 26, paragraph 3). Alternatively "sesame should be mixed with goat milk and cooked with dolphin meat. Whenever a man eats this mixture, he can prolong sexual intercourse" (*Susrut*, *chikitsha sthan*, chapter 26, paragraph 4).

All these representations in both the *Charok* and *Susrut Samhita* indicate the medical and remedial importance of men's sexuality, for which a systematic preparation method and consumption procedure needs to be followed. The central concept of ayurveda is to restore health through behavioural modification, rectification, dietary practice and lifestyle change, and this is reflected in the preparation procedure and consumption behaviour of the sex enhancement remedy. In modern Indian society, among Indian men, sexual power is seen as central to manhood. Thus, it is not surprising that products pertaining to male sexual powers constitute an important line of products for all pharmacological corporations in modern Indian society. This is especially true for the ayurvedic pharmaceutical companies, which have been quick to exploit and establish a market niche for such products. There are at least 22 brands of male impotence products including capsules, pills, penis massage creams, penis sprays, etc. found in one ayurvedic store which uses the logo of ayurveda or 'herbal', with impressive packing and sexist layout. As with the cosmetic products for women, the selling points for these products are again the herbal contents, the minimal side-effects and the effectiveness of these products.

The packaging and the names given to most male sex products, such as Patton Power Caps, Vita-Ex Gold, etc., give the impression of the ability to enhance power. By using English names for these sex products, the ayurvedic companies hope to attract middle-class men with purchasing power. Out of the 22 male sexuality-enhancement products in one ayurvedic store, 19 had English names. Of those interviewed, 5% of the male patients had consulted an ayurvedic practitioner for problems related to premature ejaculation. However, the majority of the ayurvedic *kabirajes* surveyed are not very happy about the massive development of impotence pills, as one practitioner commented that:

> "The impotence pills available in the market do not have any pharmacological appropriateness. There is no such magic-bullet in ayurveda which can increase sexual power quickly. I never prescribe those pills for my patients. I presume that the pharmaceutical companies use extra steroids to make those pills effective. I am worried about the side effects brought on by the consumption of such pills. The drug regulatory body should properly monitor those pills before giving permission to sell them in the market" (AK 1).



P 6.13-6.14 Ayurvedic impotence pills.

Source: Photos were taken by the author during participant observation in an ayurvedic shop in September 2004.

Although many male patients are reluctant to consult ayurvedic doctors concerning sexual problems such as premature ejaculation, erectile dysfunction, impotence problems, etc., a significant number of male customers purchased impotence pills from ayurvedic shops. From participant observation conducted during September 2004 in an ayurvedic medicine shop, out of a total of 134 customers observed, men's impotence pills were the fifth highest-selling category and were purchased by 10 customers. A products-sold list from another ayurvedic shop for August 1-15, 2005 showed that men's impotence pills were purchased by 10 customers out of 187. It was also observed during participant observation that most of the customers left the ayurvedic shop quickly after purchasing impotence pills. This, however, was not the case for customers purchasing other health-related products or medicines, who usually asked various questions and information about the effective use of those products.

Conclusion

Today, a larger number of consumers at home and abroad use ayurveda as their essential mode of healing. The biggest ayurvedic companies are promoting aggressive marketing campaigns all over the world - for instance, Dabur; which distributes products in over 35 countries. Ayuvedic drugs are as much the vehicle for the ideology of health commodification as allopathic drugs, regardless of their herbal and natural contents. Many modern ayurvedic graduates are paying less attention to considerations of person, place and time in providing medicine or medication, which

means ignoring a fundamental principle of ayurveda. The demand for ayurvedic health products has risen significantly because of lower toxicity, more advertising, changing outlooks of medicine and products, failures of allopathic medicine to cure chronic diseases, etc. Consumers also adopt to the consumer marketing of ayurvedic products, while cosmetics and toiletries are the best-selling products found in ayurvedic shops.

Another aspect of the global and local reach of ayurveda is the entry of women as consumers. Although there is no significant evidence to prove that ayurveda was accessible to women as medical professionals in the past, there is a dramatic shift in recent times about women entering as ayurvedic product customers. The representation of women in the *Charok Samhita* relates to human reproduction, and they were confined to the domestic sphere and were symbolised by an association with nature. The propagation of ayurvedic cosmetics and health product as natural makes women target customers also exhausted women exposure to nature. The enormous development of cosmetics, slimming and beauty products for women and sexual impotence pills for the men is a way in which ayurveda is used to epower both women and men. The entire advertising industry has promoted 'ayurvedic' health products and cosmetics in ways other than medical. All these appearances boost the uncertainty as to whether the current ayurvedic practices are indigenous or global or hybrid. The commodification of ayurveda is contrary to ayurvedic principle of 'restoring health'.

Chapter Seven

New Age Orientalism: Ayurvedic 'wellness and spa culture'

Introduction

Kabiraj Arun Gupto, who came from a *vaidya* family, is a famous and popular ayurvedic practitioner in Calcutta:

> "People are living in a very stressful environment today. Frustration, distrust and depression are common health problems. 'We', the practitioners, can no longer provide health treatment for all the health problems faced by our patients. More than half a century before, when I started ayurvedic practice as the eighth generation successor to continue my family *vaidya*, Indian 'lifestyle' was not that complex and fast. As a result of the fast pace of life, people's expectations of ayurveda as a healing system has also changed significantly. Most of my patients come after the failure of allopathic medicine, and see ayurvedic treatment as alternative health treatment; and to ensure minimum side-effects from the ayurvedic drugs that they would take".[47]

Indians today are subjected to the rapid pace of capitalist development and the capitalist mode of production. The emerging middle class have found themselves taking on an array of technical, management and professional occupations that demand not only their skills but also long hours of commitment on the job. Accumulated stress and tension take a toll in such professions. The result is that many

[47] Kabiraj Arun Gupto holds a degree in allopathic medicine in addition to being an ayurvedic *kabiraj*, as an integrated medical education course was offered from J B Roy State Ayurvedic College and Hospital during his time there.

suffer from ‘burn-out’ syndrome, on both mental and physical levels. On the physical level, the stress and tensions are translated into muscle pain, backache, and mental lethargy. All these symptoms impact greatly on the work performance, social life and social well-being of the individual.

Recognizing the need to cater to the physical and mental needs of the middle-class, large corporations have explored different services and products to cater to them. Increasingly, the developments of services and products that focus on holistic lifestyle and holistic medicine have caught the imagination of big and small corporations as well as the middle class, who become ready consumers.

This chapter examines the development of the notion of ayurvedic holistic lifestyle services and products in response to modern demands. A case study of the Vedic Village will enable us to understand how the indigenous ayurvedic health system has been commodified to cater to both local and global consumers.

New Age Orientalism

Edward Said argued that Orientalism is a mirror for looking at the Orient and/or to enter ‘oriental society’ for Occidentals. For him, the Orient was “almost a European invention, and had been since antiquity a place of romance, exotic beings, haunting memories and landscapes, remarkable experiences” - an expression of the European/Western experience of the Orient, “the place of Europe’s greatest and richest and oldest colonies” (Said, 1987:1). Said perceived Orientalism as an ideological category rather than a geographical one, and for him Orientalism expresses a “mode of discourse with supporting institutions, vocabulary, scholarship, imagery, doctrines, even colonial bureaucracies and colonial styles” (Said, 1987:2).

For Said, 'Orientalism' has three interdependent meanings: First is an academic one - and a number of academic institutions of the West still study and do research on the 'Orient' and on 'Oriental' issues. Second, the meaning of Orientalism is related to a style of thought "based upon an ontological and epistemological distinction" made between "the Orient and the Occident". Finally, Orientalism is related to a historical and material point of view. Said perceived the relationship between Occident and Orient to be an issue of power, domination and complex hegemony. Under the shadow of Orientalism, the West did not only dominate the Orient but also restructured and claimed authority over the Orient (Said, 1987:2-3). The Orient was Orientalized by the Occident and "by knowing the Orient, the West came to own it" (Said, 1987:2). Said concluded that "the structure of Orientalism is nothing more than a structure of lies" and the study of Orientalism symbolized the "European-Atlantic power over the Orient" (Said, 1987:6).

The emerging rise and growth of ayurvedic 'wellness and spa culture' in the West (Euro-America) and also in the East (India) in recent decades is relevant to Said's analysis of 'Orientalism'. This trend has been described as 'New Age Orientalism' by Selby, under the influence of which the term 'ayurveda' has become a brand name in the West, where marketing strategy targets middle class Western health consumers (Selby, 2005).

Heelas considers that, over the last few decades, the New Age Movement that has emerged has done so from the crisis of modernity, which has created a new desire for healthy life, as a group of modern people have come to perceive modernity in a crisis position. Heelas calls this particular group counter culturalist - people who are reluctant to identify themselves with the dominant capitalist system and are

“profoundly dissatisfied with mainstream values and identities”. Such people are dissatisfied with modernity for a variety of reasons, such as corruption of politicians, the alienating nature of everyday work, the consumer culture, etc., and gradually these counter-culturalists have “lost faith in the certainties of the capitalistic mainstream”. For counter-culturalists, the New Age Movement has offered an alternative way to look and perceive life, particularly for middle or upper-class people in capitalist society whose lives are not working well (Heelas, 1996:138). In the health field, counter-culturalists criticise the mainstream capitalist medical establishment, and especially allopathic dominance in health care. According to Heelas, counter-culturalists are especially dissatisfied with the isolation of Western medical practice from the decision-making process, so that they attempt to dip into ‘spirituality’ in alternative healing (Heelas, 1996: 141).

Heelas’s idea of the New Age Movement is referred to here in order to understand the development of ayurvedic services in India. Many people are afraid of Western allopathic medicine, which is expertly planned and based on clinical diagnosis. Patients feel isolated from participation in decision-making concerning the program of their own treatment because of their lack of scientific knowledge and understanding of Western allopathic treatment procedures. In contrast, alternative medical programs, such as those of health tourism for medical reasons, give patient comfortable and homely feelings because of the social support from staff and other patients (Laws, 1996: 205).

Selby (2005) considers that using the word ‘ayurveda’ in brand names has become a lucrative market strategy attracting Euro-American health consumers to the ‘New Age Orientalist desire’. Although this New Age desire has arisen from a sense

of dissatisfaction about modernity and capitalism, it has become branded as a service under capitalism. 'Wellness and spa culture', which is a relatively new phenomenon in modern society, is a good example of how 'Eastern remedies' are commoditised for consumers in India and overseas. This 'culture' involves the emergence of health tourist resorts, which provide alternative medical and health services, in India and elsewhere.

Wellness is described as "physical activity combined with relaxation of the mind and intellectual stimulus, basically a kind of fitness of body, mind, and spirit, including the holistic aspect" (Schobersberger et al, 2004:199-200). It has become a popular term in recent decades for health rejuvenation among wealthy and affluent people, although ideologically the concept of wellness requires a lifestyle change. The ultimate goal of well-being is to achieve temporary feelings of happiness, while health tourism is medically more sensitive and productive (Schobersberger et al, 2004:199-200). The 1983 World Tourism Meeting, referring to health tourism, stated that "the right to rest, a natural consequence of the right to work, must be affirmed as a fundamental right in terms of human happiness".[48] Thus health tourism is to fulfil some basic health needs for recovering mental, physical and spiritual well-being; and this is similar to the holistic definition of health by the World Health Organization.

Health tourism may be categorized according to several broad areas in terms of 'nature' and the objective of tourists in relation to it. Firstly, there is health tourism for pure medication and therapeutic reasons, which include medical operations and therapy under the supervision of a physician or therapist. The major objective here is

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[48] For details please visit http://www.medical-tourism-india.com/what_is_medical_tourism.htm.

to get medical or health care benefits and be placed under continuous medication. However, patients also consider travelling across the country to see tourist attractions, in addition to medical issues. Thus there are several reasons for choosing this tourism option. Most of these health tourists involved receive medical care under alternative systems of medicine (ayurveda or yoga in India). Such alternative therapies are often considered after the failure of conventional allopathic treatments. Finally, cost-effectiveness is another consideration that attracts overseas health tourists to India.

Secondly, pampering services, such as rejuvenating massages, herbal wraps, etc., are geared towards those who simply wish to feel good and to relax, etc.

Finally, wellness programs at many health tourist destinations offer reasonably-priced medical check-ups, tutorial classes for a healthy life, daily lifestyle packages and healthy diet (Yeung, et al, 2003).

In India, there has been a long tradition of health tourism. Kings and wealthy people in medieval India changed their domiciles frequently according to the season in order to lead healthy lives, and might build several palaces outside capital cities, using them as vacation houses for leisure and relaxation as well as for seasonal capitals. Most of the palaces were surrounded by big compounds, with lakes, flowers, gardens - and physicians. Such palaces survive in Udaipur, Jaipur, Sheikhawati, Alwar, Jodhpur, Jaisalmer, Bikaner, Simla, and Kashmir in the Himalayan foothills in Northern India; in Bhavnagar and Wankaner in Western India; in Orchha and Gwalior in Central India; and in Mysore, Ootacamund, Cochin and Travancore in Southern India (Sugich, 1992). Jag Niwas or the Lake Palace in Udaipur, is a good example of a place where royal family members “listened to the tale of the bard and slept off their noonday opiate amidst the cool breezes of the lake” (Sugich, 1992:29). Although it

was admired as a garden house for the recreation of the wealthy people, it was also used as a domicile for rejuvenation. The famous garden, Ram Bagh, was associated with Ram Bagh palace, which was used as the rest house of a maharaja outside the main city, and also as a hunting lodge and official guest house for royal visitors (Sugich, 1992:21). Sariska Palace built during the late nineteenth and early twentieth centuries by Maharaja Jay Singh, was surrounded by mountains and a huge garden that could accommodate 1000 people. Siliserh Lake and its palace in Bikaner, the Gulab Bhavan built by Maharaja Jari Singh on the bank of Dal Lake, and Woodville, the official summer residence of the Maharaja of Gondal, are also some of the best examples of such elaborate retreats (Sugich,1992). This kind of 'health tourism' became institutionalized during the British colonial rule. The British set up places in mountains and on beaches as tourist destinations for health, relaxation and the enjoyment of the beauty of nature. The idea was to lead a 'natural' way of life outside the cities and get away from the pollution that had developed in them during that time. Darjeeling in West Bengal and places in Kashmir in northern India were perhaps the best-known examples of resorts, and were known as 'heavenly paradises' where wealthy people from both the British and Indian went for a change of environment and to restore health. Many physicians suggested their patients 'change air' (*bayu poriborton*) and visit Darjeeling or Kashmir, and affluent people gradually established vacation houses in those regions. Al Hilal Palace in Kashmir symbolises this effort; it was built in 1931 by the Nawab of Bahawalpur to escape the summer heat (Sugich, 1992).

Another type of rejuvenation and relaxation for wealthy Indian males in ancient and medieval India involved was the presence of harems or *zenanas*. The tradition of harems entered India during the Arab invasion of Sindh, and later Persian.

The harems were really palaces or areas of palaces, usually located at a convenient distance from the public so that the privacy of the elite could be maintained. Although these private places were easily accessible for the royal male elites they were clearly distinguished from their own private apartments. Women accommodated in the harem included some members of royal families, their servants, slaves, maids and dancers. Except when accompanied by the royal male elites, the females in the harem seldom left it. Entrance to the royal harems was tightly controlled and visitors were carefully watched (Michelle, 1994:52). Elite males often watched recreational performances of the women, and spent time drinking. All of this was considered to bring physical and mental rejuvenation to the male elites.

In recent decades, health tourism has become one of the fastest-growing sectors of the Indian tourism industry. Many people from the developed world come to India for rejuvenation promised by yoga centres, ayurvedic massage centres, village circle clubs, wellness centres and other health tourist resorts; and 'wellness and spa culture' has become a common form of vacationing in India and abroad. In India, and covers a broad range of indigenous medical services such as ayurvedic *panchakarma* and ayurvedic massage therapy, yoga, etc. The Central Council of Indian Medicine (CCIM) under the Ministry of Health and Family Welfare recognized the potential of ayurvedic tourism in the National Policy on Indian Systems of Medicine & Homoeopathy - 2002, stating that "facilities for panchakarma and yoga would be encouraged to be offered in hotels. Indian System of Medicine parks would be developed in collaboration with state tourism authorities" (National Policy on Indian Systems of Medicine and Homoeopathy 2002, article, 16.17). A massive growth of ayurvedic resorts, spas and vacation housing under private

initiative is also a significant trend. Many resorts are located at beaches and carry out aggressive marketing campaigns to attract international health tourists.

Most visitors coming for alternative healing take part in wellness and spa activities, favouring ayurveda for medical or rejuvenation purposes. Most are Indians from the upper middle and upper classes, tourists from Western countries, or wealthy and affluent Indians living overseas. Many of the wellness packages are targeted at professional middle and upper class clients who have sufficient disposable income to engage in such consumption.

In my fieldwork I interviewed a total of 10 clients at the Vedic Village. Two Indian clients had monthly incomes of INR 30,000; another, an income of INR 50,000, two more, INR 100,000; and another, INR 20,000. Of overseas clients, two had monthly incomes of INR 45,000 (US$ 1000); one, INR 44,000 (US$ 965); and one, INR 81,000 (US$ 1,775). Two of these overseas clients had graduate-level educations and 2 were post-graduate students, while 5 of the Indians had bachelor's degrees and 1 had higher secondary education. In the Indian context, such Indian clients are considered as belonging to the upper-middle class or the upper class. Out of the 4 interviewed clients from abroad, 2 were from the USA, 1 from the UK and one from Spain.

Service providers broadcast advertisements over various media repeatedly and portray a new image of wellness and the healthy life their clients enjoy. They offer a broad spectrum of choice, and packages include physical exercise, tutorials about healthy life, yoga sessions, various ayurvedic oil and massage therapies, dietary

regulations, etc. Such advertisements for spas and wellness centre “frequently portray images of slim, bronzed and fit people enjoying an active and outgoing social life” (Laws, 1996:202). Various advertisements for dietary routines and physical exercises proclaim how individuals can influence and control their physical and mental images (Laws, 1996:202). Many advertisements and web pages for such health tourist resorts - Vedic Village in particular - use Western actors and actresses. The medicine and medical knowledge used has originated and has been practiced in India and a significant number of potential consumers are also Indian, but the advertisements show Westerners (predominantly Caucasians) enjoying healthy lives, thanks to Indian medical systems.

Promoting Vedic healthy life

‘Vedic’ is a natural way of life that attempts to achieve harmony with the environment. According to ayurvedic conceptions, a healthy life can only be achieved if the body, mind and sprit are healthy. Thus, ayurvedic treatment focuses on a holistic approach to the well-being of the body, mind and spirit. Health resorts recommend holistic treatment for their clients, to 'purify' the whole body.

The Vedic Village has been developed by a private commercial enterprise based in Calcutta, the Sanjeevani Group. The well-appointed villas and rooms reflect character, culture and cater to upper-middle-class lifestyle requirements. Currently, there are 40 well-equipped villas available for health tourists to stay in. However, the target is to build approximately 500 houses inside the village compound and sell them



P 7.1-7.2 Vedic Villas

Source: Photos were taken by the author during participant observation in the Vedic Village.

to outsiders who aspire to such a lifestyle. The cost range is approximately INR 3,000,000-4,000,000 (US$ 75,000-100,000), depending on the decoration and facilities available inside the house. One of the goals is to attract the upper middle classes to purchase these vacation houses.

Many owners stay in the Village for a period of time each year; at other periods the Sanjeevani Group manages the villas and fills them with tourists. As in many resorts with privately-owned housing units, this system guarantees a source of income for the owner, depending on the occupancy rate. The total village complex occupies 120 acre of land and is surrounded by lakes and ponds. Vedic Village is designed to rely on organic farming and natural therapies such as ayurveda, yoga, homoeopathy, and naturopathy.

The objective of the Vedic Village is to recreate a traditional Vedic way of life that focuses on simplicity of lifestyle - lifestyle that is in true with the natural environment in order to enable those living in it, however temporarily, to experience body-mind-sprit holism. To enable individuals to experience holistic living, the Vedic

Village offer comprehensive ayurvedic medication program under its wellness plan. Beside ayurveda, homoeopathy, naturopathic medical consultation and yoga practices, the Vedic Village offer three types of alternative therapies, including, ayurvedic therapies, spa massages, and wellness therapeutics. All these three segments include different massages of various duration and price. Many health tourists are attracted because of the therapeutic services that Vedic Village offers in the tranquil environment for the services.

Vedic daily routine

To obtain wellness of the body-mind-sprit, the ayurvedic routine includes the process of cleansing/purification, correction, dietary change, and behavioral motivation. In the Vedic village health resort, health tourists and residents are subjected to a daily routine called *dinacharya* (daily regime), which is prescribed in the ayurvedic text *Ashtangahridaya,* written by Maharshi Bagbhat. The text prescribes various rules and regulations to lead a healthy life on a daily basis. In the text are regulations pertaining to physical motivation, purification and postures for sleeping and waking hours; and for personal hygiene, physical exercise, and dietary intake. It also prescribes acceptable behaviour and moral and social values that individuals should uphold. Many of these values are closely related to the Hindu/Buddhist teachings of morality.





P 7.2 Vedic entrance **P 7.3** Vedic housing

Source: Photos were taken by the author during participant observation in the Vedic Village.

In the Vedic Village, the *dinacharya* regimen focuses on personal hygiene related to the mind and body for "rejuvenation". The health tourist is required to wake up with a small prayer in *Brahma muhurta*, the period of 48 minutes before sunrise, as advised in the *Ashtangahridaya*. *Dinacharya* consists of several sessions starting with the *Brahma muhurta*. A photo of the Hindu god hangs on the wall of a small therapeutic room in the Vedic Village, in front of which clients pray. After the prayer, *vaktra shuddhi,* or oral hygiene, begins - a neem twig is crushed at one end and used as a toothbrush, with herbal tooth powder, the entire process being called *dantadhavana*. After cleaning the teeth and washing the mouth, the client or tourist is given a freshly prepared herbal infusion with pure honey as a morning drink. Afterwards, clients take a sunrise walk and assemble at the Yoga Hall for a Yoga session. This is followed by *abhyangam shirodhara,* an oil massage therapy where a traditional Kerala therapy (a type of massage therapy from the Indian state of Kerala) is given. A trained ayurvedic massage therapist starts the massage with the head and gradually extends it to all parts of the body from head to foot, in a synchronized

manner. After continuing this oil massage session for an hour the therapist asks the client to take a bath with herbal soap, which is called *snana*. The therapist helps to put soap on all parts of the body. After the oil massage and cleaning session the purification sessions start. Here the principal sense organs – the eyes, ears, nose and throat - are purified, beginning with the *karnapoorana* session, when warm medicated herbal oils are dropped into the ears. This act is considered good for the prevention of headaches and ear infections. Again, a few drops of herbal oil are applied, this time deep inside the nostrils, and this act is intended to enhance the senses. *Anjana*, or *kajal*, follows, to clean the eyes. Here, a *colliriyum* (special paste) made from soot of turmeric and pure ghee is used to clean the eyes. *Dhoomapaana* is the final session to purify the sense organs. Clients are asked to inhale an antiseptic smoke generated from a burning wick made of pure turmeric. This is one of the more difficult sessions for the client who has not been exposed to the strong smell of burning turmeric. In the final sessions of *dinacharya*, the client consults an ayurvedic practitioner concerning a healthy lifestyle[49].

Holistic healing and wellness

In the Vedic Village, the holistic healing and wellness treatment programme are adopted from the ayurvedic texts. The key practices are based on the *Susrut Samhita* chapters on *ritucharya* (seasonal practices).

There are six seasons (*ritu*) spelled out in the text: winter, spring, summer, rainy, autumn and dewy. The seasons are divided into *dokhenayon* (southern) and

[49] Author has a personal experience of taking part in the *dinacharya* program. A detail description of the *dinacharya* daily regime program is also mentioned in the Vedic Village flyer.

uttornayon (northern), according to the movements of moon and sun: the rainy, autumn and dewy seasons are considered southern, when the 'god moon' (the moon, which is considered a god) becomes stronger. During these seasons, salt, food, and honey are produced in abundance and all living species become stronger. On the other hand winter, spring and summer are considered northern, when the 'god sun' (the sun, which is considered a god) becomes stronger, and bitter humors in nature increase and all living species become weaker. The six seasons each bring different natural and environmental conditions which influence the functioning of the human body, mind and humor *(bayu-pitto-koph)* (air, bile and phlegm) (*Susrut, sutro sthan*, chapter 6). As a result, the human body experiences different conditions and develops various adaptive mechanisms to maintain its balance with the natural environment.

The *Ashtangharidaya* text also describes seasonal practices and classifies the year into six seasons, which are foremost categories with similar importance and conditions to the ones they have in the *Susrut Samhita*. This text particularly emphasizes the condition of the natural environment in different seasons in terms of air, water and the location of sun and moon. It advises on the duties of individual humans to maintain their balance of health with nature during various seasons (*Ashtangahridaya, Surto sthan*, chapter 3). Various ayurvedic spas and resorts provide lessons on *ritucharya* (seasonal practices) for their clients, which primarily demand a lifestyle change.





P 7.5 Therapeutic table **P 7.6** Yoga hall

Source: Photos were taken by the author during participant observation in the Vedic Village.

Nearly one third of the total number of patients who had medical consultations in the Vedic Village for various diseases during the month of July 2005 came from overseas, including from the UK, the Arab Emirates and Bangladesh.[50] Out of 10 clients interviewed, 7 engaged in ayurvedic therapies for relaxation and rejuvenation 5 Indians and 2 from overseas. Patients visited the Vedic Village to consult the ayurvedic physician over a range of diseases, such as Irritated Bowel Syndrome, gastritis, ischemic heart disease, neurological degeneration, stomach cancer, skin disease, diabetes, sexual dysfunction, digestive disorder, mal-absorption syndrome and infantile autism.

[50] This information has been calculated from the Vedic Village Wellness centre patients' registration book.

Table 7.1

Male-female client numbers in the Vedic Village

Month	Females	Males
Jan 05	131	109
April 05	91	74
Jul 05	99	65
3 month total	321	248

Source: Client register notebook from the Vedic Village wellness centre in August 2005.

There were more female than male clients. Most of the female clients received therapy for back pain or weight loss, or got facial massages. Their main concern was to undergo 'natural' treatment with minimum side-effects. Many who visit the Vedic Village went as couples, but sometimes women visited on their own or with other women. Today, a trend of wealthy women routinely visiting health tourist destinations and spas, and indulging in massages and natural herbal health services is emerging in contemporary India.

For the months of January, April and July 05, 73% of the clients visited Vedic Village for ayurvedic therapy, 17% went for massages and relaxation services, and only 10% of the total of clients consulted an ayurvedic physician. The primary aim to visit the Vedic Village is for relaxation and stress reduction.

Table 7.2

Pattern of services for clients attending Vedic Village (numbers of clients)

Month	Medical consultation[51]	Medical consultation follow up[52]	Ayurvedic therapy	Massage	Total
January 05	13	5	185	37	240
April 05	12	4	123	26	165
July 05	15	6	110	33	164
3 months total	40 (7%)	15 (3%)	418 (73%)	96 (17%)	569

Source: Client register notebook from the Vedic Village wellness centre in August 2005.

Statistics from the month of January, April and July 05 show that about 90% of the total income of the Vedic Village wellness centre is generated from ayurvedic therapies, 6% of the income from massages that are not part of ayurvedic therapy, and only 4% of the income was generated from doctor's consultations. This is a clear indication that ayurveda is closely associated with 'relaxation therapy' and less with medical treatment options. Thus the response for wellness services has been overwhelming. There has been a consciousness in the number of people, both local and overseas visitors, visiting and using the various wellness facilities in the Vedic Village.

[51] Medical consultation mean 1st medical consultation

[52] Medical consultation follow up mean repeat medical consultation

Table 7.3

Vedic Village wellness centre's income from various sources

Month	Medical consultation (INR)	Medical consultation follow up (INR)	Ayurvedic therapy (INR)	Massage (INR)	Total(INR)
January 05	6800	1500	286,425	12,164	306,889
April 05	6300	1200	119,936	11,700	139,136
July 05	7500	1800	136,510	13,600	159,410
3 months total	20,600	3500	542,871	37,464	605,435

Source: Monthly statistical maintenance book from the Vedic Village for August 2005 (un-published and maintained by the Director).

One local visitor described his experience in the Vedic Village thus:

"I don't have any idea about ayurvedic treatment. I joined the program for my weight loss after seeing the advertisement where they advocated that the therapy they are providing is ayurvedic. I have never experienced any ayurvedic treatment. I still don't know much about ayurveda and even I don't know anything outside my celluloid weight loss therapy. Before visiting Vedic Village, I took some Kerala massage to reduce pain. They told me to take some health package but I couldn't take it due to my business. So I only can give time for one hour on Sunday and even sometimes I can't come on Sunday because of emergency. I saw the advertisements of the Vedic Village and its activities in newspapers and on television and finally decided to come here".

The costs of various service packages and treatments provided by the Vedic Village wellness centre are expensive in the Indian context and only affordable for middleclass and upper middle class professionals or the upper class elite. The Sanjeeva Spa treatment price ranges from INR 1,000 to INR 1,500 for one hour; the Kerala Ayurvedic Therapy ranges from INR 1,200 to INR 3,000 for one hour. In addition, clients have to pay an additional 10.2% service tax. One-hour Wellness Therapy costs INR 1000. In a special offer, a one-day *dinacharya* package was priced at INR 3,000[53]; a one-day Sanjeeva healing package cost INR 2,500, and the Sanjeeva Glow one-day package cost INR 2,500. A one-time medical consultation fee was INR 500. The costs of various wellness and ayurvedic therapeutic services are shown in the following table:

Table 7.4

Cost of various health services Vedic Village provides

Sanjeeva Spa		
Massage	Duration	Price (INR) + 10.2% tax US$ 1 = INR45 (app.)
Relaxing Swedish stress reduction massage	60 min 35 min	1,000 800
Children’s relaxing Swedish massage (children up to 12 years)	30 min	500
Reflexology	45 min	800

[53] Sanjeeva Spa price list.

Aromatherapy massage	60 min	1,000
Aloe & yogurt body polish with aromatherapy massage	80 min	1,500
Dead sea mineral mud wrap	80 min	1,500
Sanjeeva mud wrap	80 min	1,500
Detoxifying body wrap	80 min	1,500
Sanjeeva facials	40 min	500
Head massage/hydrotherapy	Additional	200

Kerala-ayurveda		
Therapy	Duration	Price (INR) + 10.2% tax US$ 1 = INR 45 (app.)
Abhyangam (a traditional Kerala-*Panchakarma* therapy)	60 min 35 min	1,200 800
Abhyangam and *shirodhara*	60 min	1,800
Abhyangam & *patrapinda awedana*	60 min	1,600
Shiro lepa	40 min	500
Herbal face pack	30 min	400
Face massage with *kumkumadi thailam*	30 min	400
Ayurvedamrita	90 min	3,000
Wellness therapeutics		
Therapy	Duration	Price (INR) + 10.2% tax US$ 1 = INR 45 (app.)

Cellulite breakdown	45 min	1,000
Therapeutic massage	60 min	1,000
Meridian stretching exercises	60 min	1,000
Hair nutrition	40 min	500

Source: Vedic Village wellness service price list.



P 7.7 Vedic therapists



P 7.8 A Vedic therapy

Source: Photos were taken by the author during participant observation in the Vedic Village.

There are 2 institutionally trained physicians with the Bachelor of Ayurvedic Medicine and Surgery (BAMS) degree working in the Vedic Village. Apart from this, 3 institutionally trained homoeopathic practitioners with some experience of naturopathy also provide health care services. The largest number of service providers is that of the ayurvedic-trained therapists who hold a diploma degree in ayurvedic therapy. In addition, there is 1 yoga practitioner, and there are 2 massage therapists, providing yoga training postures and massage services, respectively.

With clever marketing in foreign media, the Vedic Village has begun to gain a reputation overseas as a reputed wellness provider which provides holistic therapeutic treatments in a safe natural environment and at reasonable cost. Such a reputation has led to a steady stream of foreign visitors to the Vedic Village for alternative treatments and lifestyle experiences. One foreign visitor came here for alternative treatments.

Maria Novely[54], from UK

Maria was 27 years old and suffering from severe back pain. A year of treatment in the UK had brought no relief from her back pain, so she decided to sign up for ayurvedic treatments at Vedic Village. Maria said:

> *"I am here in India for six weeks of treatment. I had severe back pain for the past years and tried physiotherapy, osteopathy but they did not work. Then, an Indian friend studying in the same university in London and his family suggested that I try ayurvedic therapies. I decided to come to India for ayurvedic treatments, but also to travel around the country, thereby combining health and sightseeing together.*
>
> *I know very little about ayurveda. Actually, I had visited an ayurvedic doctor in UK a year back. In UK, ayurveda is seen as an alternative medicine. I understand that it deals with balancing and harmonizing the body-mind-spirit. I was informed about the Vedic Village and its ayurvedic treatment facilities from my friend's grandfather who is one of the directors of the Vedic Village.*

[54] Original name has not been used

I hope that ayurveda which is more holistic and it looks at all the different aspects will cure my back pain. I am able to come here because I have a private health insurance and most of my cost of treatment is paid by the health insurance company. Regarding ayurvedic treatment, I am not sure whether the insurance company will cover this treatment. However, my friend's grandparents are paying for me. It is just a present for me. Here I am taking some massage therapy as well as medicine. However, I can't remember the name of the medicine they prescribed or the type of therapies they provided.

Another foreign health tourist recalled her experience at Vedic Village. Marita[55] from USA visited Vedic Village for her broken bone. She subscribed to an ayurvedic package treatment. Marita commented:

"In 2004, my foot was crash, with a broken bone. I was sitting on the floor of the train in NY City. There was a very large woman who fell on me and broke my leg. During the treatment in US, I was informed that nerve of my leg has damaged. It is called complex regional pain syndrome. I took physical therapy for seven months but it did not really work well. Finally I switched to orthoclase surgery. After the surgery my leg became very painful and turned into blue colour.

I had a long interest in ayurveda and other types of alternative therapy. My father was a paediatrician. I became interested in massage therapy from a young age. If my mother had a headache, she used massage. I was always interested in medicine. From a very young age, I was fascinated about Asia and classical ancient cultures of Asia and medicines. When I was learning about massage therapy, I learned traditional Chinese medicine but I did not learned ayurveda or Indian medicine. But the concept

[55] Original name has not been used

of ayurveda is familiar to lot of peoples (especially in cosmopolitan area). There are many sensitivity centres or energy activity centres in NY called Shakra. Yoga is also quite popular and people know it came from India.

Before I came here, I did research on the internet and knew about ayurveda. But lot of things here depends on faith because I am delivering my body to the therapist and it is totally based on faith as I understand very little. It is on faith because I am ignorant about this and I don't understand the language. My therapist knows very little about English. I can't explain my feelings, the good pain or bad pain. There is a time when the pain is good and I should say it is ok because it is good but I can't express them. So, if I was fluent on Hindi or Malaya (Language of Kerala), then I might feel more confident. Sometimes I get scare because I feel that I am not in control and cannot communicate if something happened to me. But I am really improving.

I know about the Vedic village from my friend. She came here for treatment. She told me to come here when she went back to USA. Her health improved tremendously after the treatment she received here and she told me about the Vedic village. She and I studied together on public health and epidemiology in US so both of us has the background in health science. Her recommendation means a lot for me as she is not only a close friend but also studying naturopathy. So, she knows about alternative treatments.

I feel very good after taking this ayurvedic treatment. I improved so much. After I arrived in India, I came here directly in the morning and took consultation with an ayurvedic doctor. During the same afternoon, I went for treatment therapy. I had a lot of pain before but I have improved so much now. My digestion and walking also improved a lot. I have good times and bad times. I had headache, indigestion problem

but overall I feel better. But I don't feel good every moment. I am also taking some ayurvedic medicine provided by the physicians there. I was not familiar with those medicines before I came here because they were completely new to me.

Initially, I stayed seven nights in the Vedic Village and commute to the Vedic Village for treatments for another week. I signed up for a total of 24 treatments. A treatment package which include double accommodation, double food, double treatment cost INR 51,200 for seven days. When we become day visitor, we need only to pay for the treatment received. It costs INR 1,200 to 1,800 but average INR 1,600. It's a lot of money. Ayurvedic treatment in NY is also very expensive. So it is comparable with India or here. I spent a total around INR 80,000. I think it is very expensive. But I was desperate because I was really disabled for last three months, I could not even walk. I could not use the leg as the muscle is paralyzed. I could not control my leg as it is very painful. I had to use clutch to go to the toilet. My husband takes me to shower. So I was very dependent and dysfunctional. I am doing better now.

I came in India for ayurvedic therapy only because I can't afford the ayurvedic therapy in New York. India is much cheaper. Here, I also can visit my friend's family. I love India and get to know them. I can also get the relevant food related to my therapy which I can't get in NY. So these all are the extra things I can get from India. I love to travel all over India but I have to go back US after treatment. I just came for this treatment and to visit my friends in Calcutta.

A male Indian visitor, Sri Apurbo Kumar Roy,[56] visited Vedic Village for relaxation therapy to reduce muscle pain. Mr. Roy is one of the leading industrialists

[56] Original name has not been used

in Calcutta and owns a group of electronic goods manufacturing companies. Mr. Roy commented that:

> *"I heard about the Vedic Village several times but I didn't have the opportunity to visit here because of my business. I only visited here another time a fortnight ago and this is the second time. I think it is still underdeveloped as far as other housing projects concerned. But once you enter here, it is a nice place with nice environment.*
>
> *I took both Ayurvedic medication and massage here. Generally I went in Bombay and Calcutta for Kerala massage. In Bombay, there are some massage centres and I used to visit there. In Calcutta, I usually visit Tali club because that is conveniently located. I took ayurvedic massage therapy here not for illness of disease but for shoulder pain. That pain first came quite some time back and I started to take this massage one and half years before. I took some allopathic medicine and radiation therapy before but it gave temporary relief. I also took homoeopathic once but it is not effective. Ayurvedic massage ensures an overall blood circulation in the body and I basically take ayurvedic therapy for blood circulation, joint pain and back pain. My wife also came to the Vedic Village for the first time for ayurvedic massage therapy. In Bombay, I paid INR 700 and here in the Vedic Village, the charge was INR 750.*
>
> *Here, I personally I tried to come once a week and it is a rejuvenation for me. Vedic Village is not at all a poor man's luxury. It is a luxury. It is really expensive for the poor men. I also saw in the Vedic village that it should be synchronise. Here the massage is given by one man but in Bombay and Ahmadabad they give two men. Synchronize means two person will give the massage at a time, one on left side and another on right side which is more effective. If two persons give massage together for an hour, it rejuvenates the body more effectively.*

Vedic Village can be seen as one of the ways to attract tourism because it is a good place for satisfaction and rejuvenation. The most important thing is to teach people how to lead a healthy life. People are looking for longevity. So, some people are staying here for 10-15 days to experience a healthy life and that is wonderful idea. All they need to do here 10-15 days is learn to relax and lead a healthy life. We need to train people for this industry".

Another Indian female visitor recalled her experience in the Vedic Village. Aporna Shen[57], a 36-year-old Indian attorney, visited Vedic Village for a facial massage. She came here with her police-officer husband, although her husband did not take any massage therapy. Aporna commented that:

"I don't know too much about the Vedic way of life or the way Vedic Village is functioning. But I know its Indian origin. Our new generation really does not know that much about this. I would consider the medication I am taking as a therapy. It is absolutely great for reducing stress. I am taking this therapy to relax myself. I am a lawyer and my job is full of tensions and meeting different deadlines. In addition, I have a two-year-old son who also keeps me busy. Vedic village is an ideal place for relaxation and to get away from city life. I have not bought a villa or firm house yet here and we have been living in one of the villas. The Vedic village complex is absolutely beautiful. But the thing they need to improve is food, which is not very good. There is a very limited menu and I have little choice to choose from. Otherwise, everything is wonderful. There are also spa treatments available in Calcutta but this is really exceptional."

[57] Original name has not been used

As the findings have shown, local visitors to the Vedic Village are mostly Indian middle class professionals or wealthy business persons who come for relaxation therapy. Their main objective is to rejuvenate themselves and/or to relive stress. The majority of the Indian visitors do not consider Vedic Village as a place for ayurvedic medical treatment but one for massage therapy spa treatments for rejuvenation and removing stress. On the other hand, overseas health tourists take ayurveda as alternative therapy for medical reasons after the failure of conventional Western medicinal treatment.

Conclusion

This chapter has shown that 'ayurvedic wellness and spa culture' has become popular in recent decades, for several reasons.

Firstly, 'ayurvedic wellness and spa culture' has become popular in the West to cater to middle-class consumers in search of treatments for health rejuvenation and relaxation. As a result of globalization, this has also attracted middle class professionals and entrepreneurs in India. For entrepreneurs, the ayurvedic health industry is a way to make money. Likewise, for the Indian government, the creation of health tourism brings much-needed foreign currency into the Indian economy.

Secondly, Vedic Village, as representative of this development, makes use of two aspects of ayurveda: 'ayurveda' an alternative lifestyle and as an attractive medical treatment. Some clients come for the recreational lifestyle while other came after the failure of Western medical systems to treat their diseases or infirmities.

Finally, the ayurvedic texts *Susrut Samhita* and *Ashtangahridaya* contain chapters on *dinacharya* (daily regimen) and *ritucharya* (seasonal practices), *onnopanbidhi* (daily dietary habits), etc., which Vedic Village are promoting. However, it is a big investment to build such an artificial Vedic infrastructure, and investors generally have the attitude to recover their investments as soon as possible. Thus the content of ayurveda becomes a consumer product. Consumerism has already rooted in the 'ayurvedic wellness and spa culture', and ayurveda takes the form of a commodity rather than as a means of restoring health.

Chapter Eight

Conclusion

Introduction

Western modernity, which came in India during the European expansion, brought enormous changes both structurally and ideologically in the field of indigenous medical practices, and in ayurveda in particular. These changes can be related to the effort to build both the nineteenth-century colonial state and the twentieth-century anti-colonial nation-state, where medicine has been used both as part of the ‘colonizing process’ and of the ‘national revival’. The rapid expansion of globalization during the post-colonial era has caused another dramatic change in ayurveda through the commodification of various practices. Ayurveda has turned into a global health commodity instead of symbolising national identity. All these changes have led to a discrepancy of modernity and globalization in the practice of ayurveda. This dissertation was begun with the objective of re-examining some key debates about the practices of ayurveda in contemporary Indian society.

Key issues and findings

There are three significant issues addressed by this study. Firstly, this dissertation has explored the paradox of religiosity in ayurveda. This paradox was fostered by the colonial epistemology, which drew a distinction between religious medicine and secular medicine. Through applying Geertz’s definition of religion, this study finds that the Western understanding of religious and secular is inadequate to analyze the religious and secular nature of ayurvedic medicine. Although there are

mythological elements in ayurvedic practice which correspond to Hinduism, there is no strong evidence that peoples from other religious faiths were restricted to practice or use ayurvedic medicine in pre-colonial India. Historical evidence shows that Muslims in medieval India promoted ayurvedic medicine and Muslim scholars became ayurvedic practitioners (Leslie, 1976).

Veer argued that the universalistic concept of religion, and drawing a clear distinction between religion and the secular, is a Western understanding of religion (Veer, 1998). This study finds that Veer's analysis of the Western genealogy of the concept of religion is helpful to understand the religiosity of medicine in India, which was fuelled by the colonial epistemology. Perceiving ayurveda as religious therapy in colonial India intentionally made a distinction between the religious and the secular and put Western allopathic medicine under the secular idiom.

In modern Indian society, the Western understanding of the religious and the secular does not function in the field of indigenous medical practice, although practitioners and patients of ayurveda perceive ayurvedic medical practice as secular, while holding individual religious identities. However, this study argues that 'religious secularism' is separate from 'medical secularism' in modern Indian society, where medicine and religion stay together, albeit in tension. The cultural relativity paradigm, through which many scholars perceive the practice of indigenous medicines in pluralist societies, is inadequate to analyse the current trend of ayurvedic practice. Thus, a new theoretical framework is necessary to analyse the current form of ayurvedic practice in modern India and its relation with religion.

A second focus of this dissertation concerns the role of the colonial and post-colonial state. In particular, this study has pointed out how the colonial state intervened and subjugated indigenous medical practices and how the post-colonial state has revived and promoted ayurveda as part of an indigenization of health care. Chandra's idea of 'colonial cultural revolution' is important to understand how the colonial state intervened in indigenous institutions in India, and that this revolution affected not only the Indian economy but also other social arenas such as politics, culture, administration, etc. This study argues that the rise of the nationalist movement as an anti-colonial resistance during the colonial era was a middleclass elitist movement in India. The ultimate goals of the nationalist fray were to place the national elite, instead of the colonial elite, in state power. Thus, ayurvedic revival under the nationalist framework does not stand as opposed to colonial subjugation. In applying various analyses of nationalism in the Indian context, this study has shown that, in fact, the dichotomy of colonial subjugation and post-colonial revival of ayurvedic medicine has been inspired by conflicts of interest among professionals.

Simultaneously, David Arnold's idea of 'colonizing the body', with the intervention of Western allopathic medicine coming as a colonizing process, became an important trope for many nationalist scholars. An ultimate goal of the nationalist critic was to discard colonial discourse and replace it with a nationalist utopia, in which reviving ayurveda became an integral part. By contrast, this study raised the concern that the post-colonial revival of ayurveda and health indigenization are middle-class professional issues, and serve the purpose of training ayurvedic practitioners from modern institutions rather than of serving the mass of Indians. The vast majority of Indians who live in the countryside are totally excluded from the

nationalist appeal of reviving ayurveda or health indigenization during the post-colonial era. National Health Policies on indigenous systems of medicine in post-colonial India demand increasing budgetary allocations, similar professional status for the indigenous medical practitioners, etc., and thus only justify the interests of professional ayurvedic class. Primary Health Centre (PHC), or the integration of indigenous medical practices into mainstream health, is another area which follows the Western structure of health service delivery founded under British colonial rule. This study argues that the idea of the indigenization of health care through the revival of ayurveda in post-colonial India does not stand in opposition to Westernization but has simply legitimised Western hegemony.

Marxist scholars such as Baer (1997) or Morsy (1990) explored a dialectical relationship between the Western medical system and non-Western or indigenous medical systems, but this dialectic is inadequate to describe the position of ayurvedic practice in modern Indian society. Among the urban community in the city of Calcutta, there exists a tension between ayurveda and Western medicine fuelled by the nationalist inspirations of the professional and political groups, who fight to achieve political and professional goals. Patients acknowledge both the Western and indigenous medical practices, although Western medicine is the priority treatment for the majority patients.

Another important conceptual tool this study has used is the 'ideological hegemony' introduced by Antonio Gramsci. This raises concern for the role of the state, where the nation-state reproduces the hegemony of the colonial state. This study used modern ayurvedic education as a case of following a Western line introduced by

the colonial state. Gramsci showed how a ruling class establishes its hegemony in all spheres of social life after capturing power through creating a new 'organic intellectual' class (Gramsci, 1978). This study argues that, through creating a professional medical class trained in Western medicine, colonial rule in India followed the path to establish Western medical hegemony. However, after the decolonization, instead of promoting apprenticeship ayurvedic education and creating professional *vaidya* or *kabiraj* classes, the post-colonial state created an ayurvedic physician class in the form of the Western medical practitioner class and developed an integrated medical education which adopted courses from Western medicine in the ayurvedic curriculum. The post-colonial state has restructured traditions instead of reviving traditional ayurvedic apprenticeship. Modern-day ayurvedic practitioners perceive ayurvedic training from the Western allopathic outlook. This retains the reproduction of colonial hegemony by the post-colonial state.

The final aspect of this dissertation is the exploration of the global commodification of ayurveda during the port-colonial era and to argue that this commodification is in contradiction to textual ayurvedic practices. Sherry Ortner's 'nature/culture' model is particularly helpful to analyse the gender aspects of ayurvedic commodification during the post-colonial era. The massive rise of the ayurvedic natural and herbal beauty, health and cosmetics products for middle class women symbolise women's association with nature. Although woman's body has been represented in the classical ayurvedic texts *Charok* and *Susrut Samhita* as a medical body, post-colonial ayurvedic commodification portrays woman's body as a natural body which has become an integral part of women's beauty. Simultaneously, the emerging rise of the use of ayurvedic impotence pills to enhance men's sexual

power symbolises men's association with culture, which is superior to nature. Man in modern Indian society can purchase sexual power from an ayurvedic medicine shop to establish his masculine superiority. Ayurvedic drug manufacturers are re-informing the patriarchal notion of gender by highlighting women's beauty of the body.

Apart from this commodification of gender ideology by the post-colonial state, Edward Said's idea of 'Orientalism' and Paul Heelas's idea of the 'New Age Movement' are relevant to the analysis of the development of 'Ayurvedic Wellness and Spa Culture'. Said perceived orientalism as an ideological category of looking at the orient with colonial eyes (Said, 1987). Simultaneously, Heelas perceived the New Age Movement as representing the desires of counter culturalists, who were dissatisfied with the capitalist mainstream and were searching for a potential alternative. Since counter culturalists are fond of alternative therapy in the medical field (Heelas, 1996), Selby developed the idea that the branding of ayurveda as a market strategy for the Euro-American health consumer became an important part of 'New Age orientalist desire' for Eastern remedies (Selby, 2005). Through using Vedic Village as a case, this study shows how New Age orientalism has been spread in modern India for middle class professionals and entrepreneurs. With this representation, ayurveda became a wellness therapy instead of a means to restore health, and affluent people can now buy a package of 'ayurvedic healthy life' without changing their lifestyles. The commodification of ayurveda has been caused by the emergence of a new identity in modern Indian society. This study further explores how, in addition to Euro-American health consumers, emerging middleclass professionals and entrepreneurs in modern India have also became an integral part of the process of 'new age orientalization'.

Limitations and further study

One of the major limitations of this research is its middleclass character. This study focuses primarily on the formal and professional sector of ayurveda. Most of the respondents from this study, including both patients and ayurvedic practitioners, represent a particular middle class. Places such as the Central Research Institute (Ayurveda), Vedic Village, J. B. Roy State Ayurvedic College and Hospital, Dabur Ayurvedic Medicine Shop, etc., where participant observation study took place represent the formal sector of ayurveda recognized by the state. However, there is a huge informal sector of indigenous medical practices, predominantly in the countryside, which this study has ignored. One of the major reasons for this negligence is the problem of defining those practices as part of the medical system with an institutional ayurvedic framework recognized by the state. As the state does not recognize these grassroots indigenous medical practices as legal, I have been reluctant to focus on them.

Another major draw back of this study is its concentration on the urban setting, where state control is stronger than in the countryside. The three prime objectives of this study - to explore the contradictions and/or conflicts between religiosity and secularism, the discrepancy between colonial subjugation and post-colonial revival, and the global commodification and the rise of New Age Orientalism - predominantly involve middle class concerns in modern India. These three concerns have minimum impact on the vast majority of Indians living in rural areas. These concerns further boost the urban flavour of this research, which leaves open an avenue for further study beyond the modern institutional framework and formal sector of ayurveda.

The final limitation of this research is caused by its broad focus on the three major themes stated at the beginning of this conclusion chapter. Further study should narrow down and focus on one particular theme, such as religiosity vs. secularism or colonization vs. indigenisation or global commodification of ayurveda in the modern world. For instance, the rise of ayurvedic wellness and spa culture in the West and its gradual expansion in the East could be an interesting area of further study. It is relatively a new phenomenon in ayurvedic practice, developed over the last decades as part of new age orientalism. This would enable deeper understandings of how various actors influence ayurvedic practices in different historical and political circumstances.

Conclusion

As globalization has extended because of the liberal economic policy, ayurvedic practices in contemporary Indian society encounter a new phase of globalization. An essential part of this process of globalization is global commodification. Ayurveda is not an exception in this journey and has become a global health commodity. Apprenticeship *kabiraj* and home-based ayurvedic production have been replaced by modern ayurvedic physicians and large scale drug manufacturers. Ayurvedic practice in modern India has found itself with a new identity. The debate between religiosity vs. secularism, which was fuelled by the colonial epistemology, is no longer important for today's ayurvedic practitioners or patients. The dispute between colonial subjugation and post-colonial revival of ayurveda is also becoming weak. After 60 years of Indian independence, colonial intervention in the Indian medical field and the subjugation of ayurveda is not a major concern, while post-colonial state attempted to revive ayurveda within a colonial framework. The major concern today

is the creation of a new identity of ayurveda, given by the fact of globalization. With this, ayurveda has been appreciated as a wellness and spa therapy for health rejuvenation and relaxation for middle class heath consumers who have disposal income. Simultaneously, ayurveda has achieved the identity of being a ‘natural’ medicine with minimum side effect in the domestic market. The massive rise of ayurvedic health, cosmetic, beauty and sex products is a new development which has occurred in recent decades for middle class health consumers in modern Indian society. The last generation of apprentice *kabirajes* with *dhuti-panjabi* (traditional ayurvedic customs) in the city of Calcutta have almost disappeared, and quite a few those who are still alive are in old age. *Kabiraj* Arun Gupta, Goti Proshad Gupta, Krisnanando Gupta, Chandronath Chakroborti, and Robindrobed Bhatacharya, who represent generations of ayurvedic practice from ancestral times to date, probably never thought to prescribe an ‘ayurvedic wellness package’ or ‘ayurvedic slimming powder’ for their patients. As 93 years old *kabiraj* Rabindrodeb Bhatacharya stated:

> “My time has approached to leave the heaven and head the paradise. I have no interest to talk about contemporary ayurvedic practice. The ayurveda I learned no longer exists. Today’s ayurvedic practice is corrupted. I did not go to the Ayurvedic College, as it was offering integrated ayurvedic course in that time. I learned pure ayurveda from the *toll* (apprenticeship school). Let me go back home. My daughter-in-law will not allow me to enter home if I continue to chat with you and become late to get back home. My great grandfather, father and *guru deb* (master) taught me what ayurveda is and I continued that practice for the last 75 years. Now I have to say good bye” (AK4).

Appendix 1

Patients' religious representation during 15 working days (from August 2 to 19, 2004) in the Central Research Institute (Ayurveda), Calcutta

Old female patients				
Date	Hindu	Muslim	Others	Total
02.08.2004	0	0	0	0
03.08.2004	3	0	0	3
04.08.2004	8	3	1	12
05.08.2004	15	3	0	18
06.08.2004	4	0	1	5
07.08.2004	8	0	0	8
09.08.2004	3	1	0	4
10.08.2004	4	1	0	5
11.08.2004	10	0	0	10
12.08.2004	9	4	0	13
13.08.2004	6	0	0	6
16.08.2004	7	2	0	9
17.08.2004	3	2	1	6
18.08.2004	9	1	0	10
19.08.2004	10	1	0	11
Total	99	18	3	120

New female patients				
Date	Hindu	Muslim	Others	Total
02.08.2004	0	0	0	0
03.08.2004	1	0	0	1
04.08.2004	2	0	0	2
05.08.2004	7	2	0	9
06.08.2004	5	1	0	6
07.08.2004	2	0	1	3
09.08.2004	4	1	0	5
10.08.2004	2	0	0	2
11.08.2004	10	0	0	10
12.08.2004	4	1	1	6
13.08.2004	5	1	0	6
16.08.2004	5	0	0	5
17.08.2004	3	1	0	4
18.08.2004	6	1	0	7
19.08.2004	9	1	0	10
Total	65	9	2	76

New male patients				
Date	Hindu	Muslim	Others	Total
02.08.2004	3	1	0	4
03.08.2004	11	2	0	13
04.08.2004	5	1	0	6

05.08.2004	11	4	1	16
06.08.2004	3	0	0	3
07.08.2004	4	0	0	4
09.08.2004	12	1	2	15
10.08.2004	2	1	0	3
11.08.2004	6	1	0	7
12.08.2004	9	2	0	11
13.08.2004	3	3	1	7
16.08.2004	6	0	0	6
17.08.2004	11	2	0	13
18.08.2004	5	2	0	7
19.08.2004	4	1	0	5
Total	95	21	4	120

Summary

Patients	Hindu	Muslim	Others
New F	99	18	3
Old F	65	9	2
New M	95	21	4
Total	229	48	9

Source: Daily patients’ register book of the Central Research Institute (Ayurveda)

Calcutta research institute

Appendix 2

State-wise availability of AYUSH doctors for population (institutionally qualified + non-institutionally qualified registered practitioners) as of 1.1.2003

State	Total population (as per 2001 census)	ISM&H doctors on 1.1.2003	ISM&H doctors per lakh (1,00,000) of population
Andhra Pradesh	75,727,541	29,702	39.2
Arunachal Pradesh	1,091,117	NA	NA
Assam	26,638,407	1284	4.8
Bihar	109,788,224	161,010	146.7
Goa	1,343,998	NA	NA
Gujarat	50,596,992	22,617	44.7
Haryana	21,082,989	26,397	125.2
Himachal Pradesh	6,077,248	8483	139.6
Jammu & Kashmir	10,069,917	505	5.0
Karnataka	52,733,958	22,872	43.4
Kerala	31,838,619	22,968	72.1
Madhya Pradesh	81,181,074	56,732	69.9
Maharastra	96,752,247	83,167	86.0
Manipur	2,388,634	NA	NA
Meghalaya	2,306,069	229	9.9
Mizoram	891,058	NA	NA

Nagaland	1,988,636	1997	100.4
Orissa	36,706,920	8781	23.9
Punjab	24,289,296	33,542	138.1
Rajasthan	56,437,122	29,323	51.9
Sikkim	540,493	NA	NA
Tamil Nadu	62,110,839	37,378	60.2
Tripura	3,191,168	NA	NA
Uttar Pradesh	174,532,421	96,342	55.2
West Bengal	80,221,171	45,280	56.4
A.& N. Lands	356,265	NA	NA
Chandigrah	900,914	297	33.0
D & N Haveli	220,451	NA	NA
Daman & Diu	158059	NA	NA
Delhi	13,782,976	6118	44.4
Lakshadweep	60,595	NA	NA
Pondicherry	973,829	NA	NA
Total (India)	1,027,015,247	695,024	67.7

Source: AYUSH, 2003:87

Appendix 3

State-wise numbers of AYUSH doctors (Institutionally qualified + Non-institutionally qualified registered practitioners), hospitals, hospital beds and dispensaries as of 1.1.2003

State	Registered Ayurvedic practitioners	No of hospitals	Bed strength	Ayurvedic Dispensaries
Andhra Pradesh	15,028	8	464	1437
Arunachal Pradesh	NA	1	10	5
Assam	250	1	100	329
Bihar	131,121	11	1120	522
Delhi	5069	6	295	122
Goa	NA	3	185	22
Gujarat	17,081	48	1845	539
Haryana	18,895	6	635	410
Himachal Pradesh	6927	22	400	964
Jammu & Kashmir	343	2	100	247
Jharkhand	NA	1	120	NA

Karnataka	11,144	119	6967	563
Kerala	13,413	110	2798	759
Madhya Pradesh	47,365	36	1410	2093
Maharashtra	52,372	78	11,304	469
Mizoram	NA	NA	NA	1
Nagaland	0	NA	NA	NA
Orissa	3810	7	343	524
Punjab	20,379	14	1044	489
Rajasthan	23,483	79	804	3469
Tamil Nadu	3542	5	425	10
Tripura	NA	NA	NA	30
Uttar Pradesh	57,118	2047	10,477	713
Uttaranchal		322	1605	NA
West Bengal	2923	3	309	254
Chandigarh	0	1	150	5
Pondicherry	NA	NA	NA	12
Daman & Diu	NA	1	5	1
Sikkim	NA	1	10	NA
CCRAS	NA	1	25	NA
Ministry of Railways	NA	24	600	38
Ministry of	NA	NA	NA	129

labour				
Ministry of Coal	NA	NA	NA	28
CGHC	NA	NA	NA	31
Central Research Councils	NA	NA	NA	32
Lakshadweep	NA	NA	NA	4
Total	430,263	2958	43,560	14,252

Source: AYUSH, 2003[58]

[58] Ayurvedic practitioners registered in West Bengal have increased to 3096, according to *Health on the March West Bengal 2003-04*: 223, Directorate of Health Service, Government of West Bengal.

Appendix 4

Summary of Infrastructural facilities for ayurveda under AYUSH (all over India)

	Facilities	Availabilities
1	Hospitals	2253
2	Beds	43,803
3	Dispensaries	13,925
4	Registered practitioners	432,625
	Institutionally qualified practitioners	333,742
	Non-institutionally qualified practitioners	98,883
5	Undergraduate colleges	209
	Admission apacity	9250
6	Postgraduate colleges	59
	Admission capacity	900
7	Licensed pharmacies	7772

Source: AYUSH, 2003:21

Appendix 5

Statements of patients attended at OPD during the reporting period from 1st April to 31st March 2003-04 in the Central Research Institute (Ayurveda) Calcutta

Disease	New		Old	
	Total male (Adult + child)	Total female (Adult + child)	Total male (Adult + child)	Total female (Adult + child)
Diarrhoea	30	18	73	48
Piles	153	65	465	178
Typhoid	26	13	129	81
Epilepsy	16	5	64	108
Peptic Alsur syndromes	844	574	2246	1563
Rheumatic' Arthritis	67	218	242	607
Renal stone	2	2	8	17
Tumour	8	6	26	12
Paralysis	1	1	2	2
Fistula	43	14	150	31
Vomiting	-	2	-	3
Goitre	-	3	22	3

Hepatobiliary disease	81	36	310	99
Tumour	-	3	-	3
Lumboceatica syndrome	50	44	108	137
Tumour	1	5	25	9
Uterine prolepses	1	3	10	4
Heart disease	28	18	76	47
Fever (general)	41	47	52	72
Coughing	180	65	366	209
Worm infection	78	44	170	107
Emaciation	9	9	15	16
Jaundice	8	3	12	9
Allergy	23	20	40	40
Pain in the knee joint *(katisula)*	66	47	174	131
Constipation	194	107	469	280
Oral disease	18	9	32	28
Painful urination (Mutra Kriccra)	68	22	166	69
Eye diseases	2	1	3	3
Nasal diseases	7	2	18	5
Sneezing	33	15	82	31
Anaemia	23	14	49	53

Dysfunctional uterine bleeding	5	146	18	381
Loose motion	213	83	630	247
Diabetic mellitus	289	156	289	156
Paralysis due to CVA/TIA	36	15	29	11
Bleeding due to disorder of cloying factors	5	2	1	8
Diseases of blood	14	6	23	28
Menstrual disorder	-	111	-	148
Asthma	147	55	289	110
Headache	47	51	61	87
Elephantitis due to filasiasis	2	1	3	1
Osteoarthritis	157	221	349	413
Oedema	11	14	29	28
Lenkoderma	52	52	151	205
Joint pain	5	6	13	23
Allergic urtecaria	11	8	15	5
Nightmare	10	-	3	2
Skin disease	137	101	171	159
Abdomen pain	188	150	185	287
Pain in chest	2	-	9	-

Abscess	18	8	6	8
Eczema	72	25	130	54
Rheumatism	454	459	736	870
Blood disease	9	55	21	1
Enlargement (Vrddhi)	21	3	11	1
Ulcer and inflammation (Vidradhi)	7	3	5	4
Hepatic disease	11	6	21	5
Disorder of uterus	-	2	-	19
Duodenal Ulcer	49	20	105	43
Vyan B. Vaisamya	23	39	54	233
Medoroga (Obesity)	11	31	25	78
Others	409	160	412	195
Total	4515	3424	9398	7816

Source: Central Research Institute (Ayurveda), Bidhannagar, Kolkata, C.C.R.A.S., Dept. Of AYUSH, Ministry of Health and Family Welfare, Government of India, Annul Progress Report 2003-2004:70-7.

Appendix 6

Comparative table about examination system between BAMS course and MBBS course

(BAMS Course)

6 months	6 months	6 months	Examination
1	2	3	1^{st} professional examination (during third semester)
4	5	6	2^{nd} professional examination (during sixth semester)
7	8	9	3^{rd} professional examination (during nineth semester)
1 year			Internship
Five and a half years			Total

MBBS Course

6 months	6 months	6 months	Examination
1	2		1^{st} professional examination (during second semester)
3	4	5	2^{nd} professional examination (during fifth semester)
6	7		3^{rd} professional examination part 1 (during seventh semester)
8	9		3^{rd} professional examination part 2 (final professional examination during 9^{th} semester)
1 year			Internship
Five and a half years			Total

Appendix 7

Facilities available for treatment in ayurvedic system of medicine in West Bengal 2002-03

State Facility	Number
State Ayurvedic Dispensaries	188
State Ayurvedic Hospitals	3
Available Hospital Beds	215
BPHC with Ayurvedic Units	92
PHC with Ayurvedic Units	15
Ayurvedic Pharmacy and Garden	1
Ayurvedic Drug Testing Laboratory	1

Source: *Health on the March West Bengal 2002-03*: 215, Directorate of Health Service, Government of West Bengal and Five Year Plan 2002-03, Volume 2:163, Planning Commission, Government of India

Interview Questionnaire for individual interview

Cover Page

Repackaging ayurveda in post-colonial India: Revivalism and global commodification

Questionnaire for the Ayurvedic practitioners/related professionals

General Information

My name is Md. Nazrul Islam, I'm a PhD candidate of the Dept. of Sociology, University of Hong Kong, and I would like to do a study on *"Repackaging ayurveda in post-colonial India: Revivalism and global commodification".*

If you agree I would like to interview you on your opinion and experience about these issues. This interview will last for about one hour. I would like to tape record it. No personal information will be asked/ or: any personal information is being kept separately from the main interview and is only accessed by myself. Do you have any further questions concerning the study? May I interview you now/ shall I come back at a more convenient time?

1. This research is a part of PhD degree and all the findings will only be used for my particular academic purpose.

2. Institutionally this study is conducted under the Dept. of Sociology, University of Hong.

Inform Consent

I hereby declared that I am providing this information willingly and aware that my information will only be used for this particular research purpose.

Date__________________ Signature of the Respondent__________________

I hereby declared that the information I am collecting will only be used for this particular research purpose. I will ensure the confidentiality of the informant and information and after completion of the research all the information will be destroyed.

Date__________________ Signature of the Researcher________________________

1. Background question

1.1. For how long have you been practicing?

1.2. Why did you choose this profession?

1.3. What types of training you do have?

1.4. Do you have specialization in any particular area?

1.5. What are the common problems you have encountered while attending to patients?

1.6.For what kinds of problem do patients usually visit you?

1.7.Do you charge any visiting fee? If yes, may I ask how much?

2. Ayurveda vs. Allopathic medicine

2.1. Do you have any professional training/knowledge about Western medicine?

2.2. Do you think that your status is much like that of your Western counterparts?

2.3. Have you ever discovered that after participating, in Western-style training programs, the status of indigenous medical practitioners had been upgraded?

2.4. How do you perceive the Western style of training program?

2.5. How do the patients behave towards a qualified and a non-qualified Ayurvedic practitioner?

3. Colonizing the medicine

3.1. What kinds of impact do you think the British colonization made on Ayurvedic medicine? (Negative, positive, why and how)

Do you think that Ayurvedic medicine is now in a better position than during the colonial regime?

4. Health policy, system and integration of Ayurvedic medicine

4.1. Do you think that the government gave much attention to Ayurvedic medicine after the independence?

4.2. How do you perceive the integration of Ayurvedic medicine into the state health policy and systems?

4.3. Do you notice that the current state health policy has adequate avenues to provide Ayurvedic medical care?

4.4. What types of health services delivery do you expect (i.e.: market oriented, state owned, private, and public)?

5. Ideology/politics

5.1. Do you find any relation between communist rule in West Bengal and the practices of Ayurvedic medicine?

5.2. How do you correlate Ayurvedic medicine with Indian nationalism?

6. Religion (cultural category)

6.1. Do you find any relation between your religious belief and professional choice?

6.2. Do you prescribe some food as medicine or medicine as food or any behavioral taboo? (If yes, what kind of foods and how? Or do you suggest your patients follow certain behavioral taboos?)

6.3. How do you perceive the relation between *Ayurveda* practices and Hinduism in India?

6.4. Do you notice any relation between your caste and Ayurvedic medical choice?

7. Gender and media

7.1. Do you notice any relation between gender and healing/remedial choices?

7.2. Do you discover that Ayurvedic drug companies are feminizing Ayurvedic medicine, and/or provoking a new gender ideology?

8. Market and capitalism

8.1. Do you make any difference between branded and generic medicine during prescription? Why?

8.2. How do you get the ideas about a particular brand?

8.3. Do you discover more options to choose Ayurvedic medical products and services in the contemporary era?

8.4. Do you notice that new consumers are being created and that demands are rising for Ayurvedic medical products and services?

8.5. What are the key factors determining the consumption behaviour of Ayurvedic medical products and health services (affordability, accessibility and effectiveness)?

9. Socio-economic status.

9.1. Was your professional choice influenced by your family background, socio-economic status?

9.2. Do you notice any relation among age, educational status and remedial choice?

9.3. Do you find any social hierarchy involved with the choice of healing (socio-economic or professional, and class differences)?

9.4. Do you feel that trained practitioners are more expensive than non-trained practitioners are?

9.5. Do you consider any difference between a qualified and non-qualified Ayurvedic practitioner? (How do you perceive their roles in health service delivery?)

10. Globalizing Ayurveda.

10.1. How do you perceive the use of modern technologies and laboratories in Ayurvedic medical sectors?

10.2. What do you think about the standardization and patenting of Ayurvedic medicine?

10.3. Does media advertisement made any impact on your choice of Ayurvedic medicine?

10.4. Do you think that Ayurvedic medical practitioners should have knowledge about Western medical sciences?

10.5. How do you perceive cross-practice?

Respondent Number –

Respondent Category and number	
Date of interview	
Respondent location	
Name	
Address	
Date of Birth	
Profession	
Sex	
Education	
Religion and Cast	

Monthly Income	
Family patterns	

Thank You

Interview Questionnaire for individual interview

Cover Page

Repackaging ayurveda in post-colonial India: Revivalism and global commodification

Questionnaire for the consumers/ patients

General Information

My name is Md. Nazrul Islam, I'm a PhD candidate of the Dept. of Sociology, University of Hong Kong, and I would like to do a study on *"Repackaging ayurveda in post-colonial India: Revivalism and global commodification"* .

If you agree I would like to interview you on your opinion and experience about these issues. This interview will last for about one hour. I would like to tape record it. No personal information will be asked/ or: any personal information is being kept separately from the main interview and is only accessed by myself. Do you have any further questions concerning the study? May I interview you now/ shall I come back at a more convenient time?

1. This research is a part of PhD degree and all the findings will only be used for my particular academic purpose.

2. Institutionally this study is conducted under the Dept. of Sociology, University of Hong.

Inform Consent

I hereby declare that I am providing this information willingly and am aware that my information will only be used for this particular research purpose.

Date__________________ Signature of the Respondent__________________

I hereby declared that the information I am collecting will only be used for this particular research purpose. I will ensure the confidentiality of the informant and information and after completion of the research all the information will be destroyed.

Date__________________ Signature of the Researcher_________________________

Respondent Number –

1. General features about Ayurvedic remedy use

1.1. Would you please tell me your difficulties/illness/disease?

1.2. For how long have you been suffering from this difficulty?

1.3. How do you know about the ayurvedic system?

1.4. Why do you choose ayurvedic medication/medicine?

1.5. Do the other members in your family use ayurvedic medication?

1.6. What types of remedies are you using?

1.7. Would you please briefly describe your experience after coming under ayurvedic medication?

1.8. Are you paying any charges? (If yes, may I ask how much?)

1.9. Do you ever compare the cost of different medical systems?

*1.10. Do you have any idea why your charge is free (for the IPD patients in CRI only)?

2. Ayurveda vs. Other systems of medicine

2.1. Do you use other systems of medicine for the same difficulty?

2.2. How do you compare different systems of medicine (in terms of affordability, effectiveness, and accessibility, for example)?

3. Colonizing the medicine

3. 1. What kinds of impact you do think the British colonization made on Ayurvedic medicine? (Negative, positive, why and how).

Do you think that Ayurvedic medicine is now in a better position that during the colonial regime?

4. Health policy, system and integration of Ayurvedic medicine

4.1. Do you think that the government gave much attention to Ayurvedic medicine after the independence of India? Do you think that ayurvedic physicians have much scope to work?

4.2. How do you perceive the integration of Ayurvedic medicine into the state health policy and systems?

4.3. What type of health services delivery do you expect (e.g. market oriented, state owned, private, public)?

5. Ideology/politics

5.1. Do you find any relation between Communist rule in West Bengal and the practice of Ayurvedic medicine?

5.2. How do you correlate Ayurvedic medicine with Indian nationalism?

6. Religion (cultural category)

6.1. Do you consider some of your food as medicine or medicine as food? (If yes, what kind of foods and how? Please explain). Do you follow any food or behavioural taboo?

6.2. How do you perceive the relation between *Ayurveda* practices and Hinduism in India?

6.3. Do you notice any relation between your caste and Ayurvedic medical choice?

7. Gender

7.1. Do you notice any relation between gender and healing/remedial choices?

7.2. Do you discover that Ayurvedic drug companies are feminizing Ayurvedic medicine, and/or provoking a new gender ideology?

8. Market and Capitalism.

8.1. Do you prefer any particular brand when choosing your remedy?

8.2. Do you discover more options to choose Ayurvedic medical products and services in the contemporary era? (If yes, how?)

8.3. Do you notice that new consumers are creating, and demands are rising, for Ayurvedic medical products and services?

9. Socio-economic status.

9.1. Do you notice any relation between social prestige and remedial choice?

9.2. Do you notice any relation among age, educational status and remedial choice?

9.3. Do you find any social hierarchy in the choice of healing (socio-economic or professional, and class differences)?

9.4. Do you consider any difference between qualified and non-qualified Ayurvedic practitioners when choosing them?

10. Globalizing Ayurveda.

10.1. How do you perceive the use of modern technologies and laboratories in Ayurvedic medical sectors?

10.2. Do you prefer to visit only trained professionals in modern medical institutes or any Ayurvedic medical practitioners?

10.3. What is your idea about drug standardization?

10.4. Does media advertisement make any impact on your choice of Ayurvedic medicine?

10.5. Do you think that Ayurvedic medical practitioners should have knowledge about Western medical science?

10.6. How does you perceive cross-practice?

Respondent Category and number	
Date of interview	
Respondent location	

Name	
Address	
Date of Birth	
Profession	
Sex	
Education	
Religion and Cast	
Monthly Income	
Family patterns	

Thank You

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